Komatra Chuengsatiansup, M.D. Ph.D.

DELIBERATIVE ACTION

Civil Society and Health Systems Reform in Thailand

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Ph.D.

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Acknowledgements

The health systems reform movement in Thailand has been a collective learning experience. In the past three years, the reform initiative has gradually expanded to include a wide range of civil society organizations in the process of rethinking and reinventing national health systems. Among these actors, there were different perspectives on the dimensions of health systems reform: what should be the objects of reform, which characteristics of new health systems were desirable, and how to achieve them. More importantly, the dynamic process of reform that has unfolded over the past three years can be interpreted differently from various viewpoints. This report does not claim to be an absolute, undisputable interpretation of what has taken place in the health systems reform movement. Any interpretation is always rendered from a specific standpoint, and therefore is always contested and subjected to endless reinterpretation from differing viewpoints.

This book is the result of an action-research project entitled "The Roles of Civil Society and Health Systems Reform," generously supported by the Rockefeller Foundation. This support made it possible to put into action the concepts, ideas, and strategies, which would otherwise be impossible to realize. The project represents a collaborative effort among various civil society organizations, state agencies, and academic institutions. On behalf of the Health Systems Research Institute, the Health Systems Reform Office, and the Society and Health Institute, I would like to take this opportunity to express deepest gratitude to the Rockefeller Foundation and numerous active citizens as well as various civil society organizations that have contributed greatly to the ongoing health reform movement in Thailand. It is hoped that the enthusiastic effort during these three years will create a long lasting civic tradition in the domain of health policy and action.

My appreciation is also extended to friends and colleagues who supported me in various ways during the process of writing. I wish to particularly thank Chatichai Muksong, Paranath Suksuth, Warunya Petkhong, and Pavinee Swatdimanond for their assistance in preparing the typescripts. Gary Suwannarat assisted in the editorial process of which I am grateful. Last but not least, I am indebted to Chris Baker whose valuable suggestions and insightful comments had greatly strengthened the final manuscripts.

Health systems reform, as well as other social reform, is not a one-time endeavor. Rather, it is a continuous process of changes to solve new problems, to create new possibilities, and to achieve new health status. The reform initiative in Thailand has yet to be completed and will never be completely accomplished. New situations will surface, new problems will emerge, and new visions of good life will inspire and renew the attempt of ordinary citizens to join in a collective effort to build a just, peaceful, and healthy society. Hopefully, this book will be an inspiration for further actions and a small contribution towards a stronger civil society and a healthy collective life here in Thailand and elsewhere.

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Summary

Deliberative Action:
Civil Society and Health Systems Reform in Thailand

This book provides an account of civil society engagement in health systems reform in Thailand. In order to depict and explain lessons learned from the effort to promote the roles of civil society in shaping the future of the Thai national health system, this book offers a background review of how the health systems reform movement in Thailand was initiated, the guiding principles, and how the working strategies played out in the first three years of the reform process, 2000-2003. To better understand the roles and contributions of civil society in social changes, the book provides a summary review of civil society concepts and theory. Civil society is defined as "an autonomous sphere of social interactions in which active individuals and groups form voluntary associations and informal networks and engage in activities with public consequence."

The aim of the health systems reform movement was to create a broad-based reform movement to achieve two strategic objectives: (1) The restructuring of institutional arrangements through legislative action, and (2) The forging of a new collective health consciousness. To achieve these two objectives, a triangular approach was employed as the reform working strategies. These are (1) Creating a knowledge base for reform, (2) Social mobilization and civil society movement, and (3) Political engagement and creating a legal framework. These working strategies were translated into stages of action over the three years of the reform movement through the Health Systems Reform Office (HSRO) and the National Health Systems Reform Committee (NHSRC).

The first year aimed at building the knowledge base and creating an infrastructure to mobilize civil society in the reform movement. By the end of the first year, various forums were organized to inaugurate the dialogue on health problems among stakeholders. In the second year, an initial framework for health reform was proposed as a basis for deliberation. Extensive debates on the proposed framework were encouraged. Hundreds of forums and workshops at various levels were organized to scrutinize the framework. By the end of the second year, a draft of the national health bill was introduced, taking into consideration the ideas and suggestions gathered from the debates. Following hundreds of local, provincial, and regional forums, a national health assembly was organized to revise the final draft of the bill. The third year involved promoting health initiatives in accordance with the bill, which was awaiting approval from the Cabinet and Parliament.

The analysis of the reform process suggests that the most important aspect of mobilizing civil society in health systems reform was the creation of the civic deliberation process. Various forums, meetings, conventions, and conferences at different levels created a much needed arena for public discussion. This new public space provided the opportunity for deliberation on how health and medical conditions should be understood and what were the most important changes needed to achieve the desirable health systems. In order to engage the broadest range of social actors and civil society organizations in the reform process, it was realized that the concept of health needed to be expanded from the biomedical definition towards a more holistic, inclusive, and multidimensional definition of health. In the process of reform, health was consequently redefined to emphasize not only biological and psychological aspects but, more importantly, social and spiritual aspects of well-being and wellness. Various activities aimed at expanding and redefining health concepts are provided as working examples in this report.

The book also presents detailed accounts of how concepts of health systems reform and civil society mobilization were translated into practice. Particular emphasis was on civic engagement and the creation of the deliberative function of health system governance. During the deliberative process, active citizens were empowered and the status quo was challenged. Health, as it was percieved and deliberated in civic forums, was not so much an individualized, depoliticized state of being achievable solely by individuals adopting a personal healthy lifestyle and passively following official authority or bureaucratic policy. Rather, health was viewed as socially determined, and public policies that often greatly affect health were deemed too important to be left to bureaucrats, politicians, and experts. It was this shift in the view of health, and of health policies and politics away from the conventional model to one that embraced the active roles of citizens that can be said to be the true object of reform in the Thai health systems reform movement.

The book ends with a set of recommendations regarding strategies to enhance the roles of civil society in health reform. It suggests that in order to involve a greater spectrum of civil society organizations in health reform, the concept of health as well as the framework for reform need to be expanded to become more inclusive. Policy processes and legitimate health actions also need to be percieved in a more pluralistic manner. Coordination mechanisms to encourage collaboration between civil society organizations and national agencies are crucial and the coordinating body must be flexible and able to work in a less structured, more informal way. Information and databases on existing civil society organizations are also crucial. The book also suggests that creating knowledge and understanding of civil society and health through research is essential for creating long term policies and strategies for an increased role of civil society in health and social change.

Chronology of Events

Health Systems Reform Movement in Thailand

January 2000.
Board of Health Systems Research Institute (HSRI) approves the establishment of Health Systems Reform Office (HSRO) as an interim office to coordinate the national health systems reform movement.

February - July 2000.
Commission works to review and synthesize 15 components of the existing body of knowledge on the health system and health sector reform. The process of review aims at creating a knowledge base for a broad-based health reform movement and the drafting of the National Health Act.

March 2000.
Senate Committee on Public Health present the "Health System of the Nation," proposing health system reform in accord with the new constitution.

July 2000.
The Office of the Prime Minister issues the National Health System Reform Regulation, B.E. 2543, establishing the National Health Systems Reform Committee, chaired by the Prime Minister. The Committee is tasked with reform of the national health system, to be embodied in the National Health Act within three years.

August 2000.
National Health System Research Conference on "Civic Deliberation towards Health of the Nation" held. More than 1,500 participants participate in discussions on problems regarding the

national health system, health situation and trends, and the desired health system. Twelve civic groups organize separate forums to express their views and share their experiences on various aspects of health systems.

August - November 2000.
Research and technical groundwork are undertaken to create a strong knowledge base for health system reform.

November - December 2000.
An initial conceptual framework for the national health system is published and distributed.

January - August 2001.
More than 500 workshops and forums are convened at various levels for individuals, organizations, civic communities, and public agencies to develop a consensus on the basic values citizens feel should be incorporated in the reform agenda.

September 1-5, 2001.
Health Reform Bazaar is organized for civil society organizations to share and exchange their views and experiences. Technical sessions as well as the demonstration of a civic forum in the form of the National Health Assembly are convened. More than 150,000 people attend the Bazaar and participate in various activities during the event.

A declaration proposing principles, ideas and concepts for health system reform is drafted during the assembly and delivered to the Deputy Prime Minister attending the closing ceremony.

October - December 2001.
A draft of the main content of the national health bill is produced and widely distributed among civil society networks.

February - April 2002.
550 district civic forums are convened to discuss the main proposals of the national health bill. More than 40,000 people participate in the process.

April - May 2002.
The first draft of the National Health Act is produced. Contents derive from the technical review taskforces as well as from district civic forums.

June - July 2002.
Provincial health forums are organized in all provinces to discuss the draft of the bill. Forums for specific issues of concern are also created to discuss these topics. More than 100,000 people participated in these forums.

August 8-9, 2002.
National Health Assembly 2002 is convened; 4,000 participants discuss and work to finalize the bill. Prime Minister Thaksin and Health Minister vowed to process the bill according to the wish of the assembly.

September 2002.
The National Health System Reform Committee approves the final draft of the bill.

October 16, 2002.
The bill is transmitted to the Cabinet.

November 2002.
A national campaign for the bill is organized; 4.7 million signatures are gathered and presented to the Speaker of the Parliament to show popular support of the bill.

December 18, 2002.
The bill is considered by the screening committee before being presented to the Cabinet. Ministry of Public Health representatives request a month for internal discussions.

January 2003.
A group of doctors from private, for-profit hospitals lobby to block the bill. They fear that the bill would prohibit the operations of for-profit hospitals.

January 13, 2003.
A consultative meeting is convened to resolve controversial issues. Consensus is reached and the draft bill amended. The final draft is completed and awaits Cabinet approval.

June 3, 2003.
The cabinet extends the working period of the National Health System Reform Committee and Health System Reform Office for another two years to continue working on implementation of the bill.

August 2003.
National Health Assembly is organized to illustrate how local agenda should be linked to national policies. More than 2,000 representatives of civil society participate in the conference.

December 2003.
The bill remains in limbo.

February 2004.
A popular campaign in order to gather 50,000 signatures in support of the bill was launched. This popular campaign was based on the 1997 Constitutional provisions by which civil society organizations with 50,000 supporting signatures can directly propose new laws to the National Parliament without the approval of the government.

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1
Introduction: Civil Society and Health Systems Reform in Thailand

"... the structure of our current public health system is arranged to deal with diseases of biophysical origin and not with socially originated health predicament. As a result, health care has been a passive system waiting for those who have already got sick to come to get medical treatment instead of proactively reaching out to bring about health and well-being.

Health must be understood as well-being in physical, mental, social, and spiritual senses. Health, therefore, is embedded in every aspect of human and social development. Health, and not GDP or any economic outlook, should be perceived by all as a national ideological goal. Health includes and transcends economic development... Health systems reform therefore equals a reform of the meaning of life. In other words, a reform of how we perceived as a worthy life and what we should hold as ultimate aim of our existence."

Prawase Wasi

❑ Reconceptualizing health reform

The founding of Siriraj Hospital as the first public hospital in 1888 marked the beginning of the transformation of health and medical care in the history of the Kingdom of Siam. Although it took several more decades before Western-style medical care was accepted by the public, the establishment of a modern hospital and medical school at Siriraj Hospital laid the foundation for the new health systems of the nation. In

the decades that followed, modern medical knowledge not only changed how sicknesses were cured, but also transformed the way health was defined and conceived. Most importantly, it has changed the structure of power, transformed the authority of the state, established the dominance of medical professionals, and altered the roles of individuals, families, and communities in dealing with both individual and social health problems (see Komatra & Chatichai eds. 2002; Thaweesak 2000, 2002).

Prior to the establishment of Siriraj Hospital, the state played a limited role in providing health care or medical welfare for the general public (Pensri 1985). Health and healing was the responsibility of families and community members, relying mostly on local healers. In such a historical context, the inauguration of freely available medical care for the general public constituted Thailand's first reform of the nation's health care system. With enormous support from the government and extensive technical assistance from abroad, modern medicine and modern health care systems gradually replaced traditional systems of healing (Chanet 2002). Modern medicine has since become the main means of addressing health and medical problems and public medical facilities have been the major provider of medical care in Thailand.

During recent decades, Thailand has witnessed progressive development in health status. National health indicators have shown significant improvement. The life expectancy at birth of Thai people has markedly increased. Infant mortality and maternal mortality rates have greatly improved. Various infectious diseases were either controlled or eradicated. Health care facilities have expanded to cover both urban and rural areas. This achievement of health development in Thailand, however, came at a high price. Thailand has spent as much as 250 billion baht annually on health expenditures, rising 10 percent yearly (Ministry of Public Health 2002: 52). While a number of old problems have been successfully dealt with, new and more challenging problems

are lurking on the horizon. Preventable health threats, for example, accidents, AIDS, dengue hemorrhagic fever, leptospirosis and tuberculosis continue to challenge the nation. Non-communicable diseases such as diabetes and cardiovascular diseases as well as other behavior related health problems pose new challenges to the dominant biomedical approach and hospital-based health system (Ministry of Public Health 2001).

One of the main problems of the conventional approach in health development is that health has been individualized as well as narrowly conceived as the result of medical intervention. This medicalization of health and its emphasis on curative aspects has accelerated medical expenses and led many countries to initiate the reform of their health care systems. Attempts to reform national health care financing have been made in many countries in order to contain costs while providing better coverage of care for the population (see Sanguan & Mill eds. 1998). Medicalization of health is, however, not only costly but also inadequate to address the complex interplay of physical, socio-cultural, economic, and political factors that greatly affect health at individual and collective levels. Achieving health and well-being of the population requires more than the reconfiguration of medical care and changing its financing system.

If health is perceived not as the result of medical cure, but rather as a state of individual and collective well-being inseparable from its socio-political contexts, the object of reform might be rather different from the aim of the healthcare reform movement which has been spreading worldwide in the past few decades. The object to be reformed is not so much the "healthcare system" as the "health system" in the broadest sense. In other words, it is the systems and processes at various levels which affect personal and collective health that need reform, not the healthcare system per se. Such a health system reform (HSR) approach calls into question various aspects of health-related affairs not scrutinized by conventional healthcare reform (HCR)

approaches. How health is conceived, defined, and achieved outside the healthcare domain as well as how systems related to health are constructed and maintained also need to be reconsidered.

Perceiving health as the result of dynamic interplays of bio-psycho-social factors requires that health sector reform must go beyond the restricted conventional approach of reforming healthcare and medical services; instead creating a reform process from a broader perspective. Is it possible to create a reform movement that would transform health in a more holistic manner? What is the health reform agenda that enables cross-sectoral dialogue and greater public involvement to reshape the nation's health system? How can health system governance be reorganized to invite the broadest range of actors into health policy processes and actions? It was with these concerns and considerations that a reform initiative was launched in Thailand in 2000 for "health systems reform".

❑ Thailand's Health Systems Reform Initiative: Toward a New Approach in Health Reform

On May 9, 2000, the Thai government approved a proposal establishing a platform for national health systems reform. The proposal called for the appointment of the National Health Systems Reform Committee (NHSRC) to address the problems in the current health systems of the country. To bypass bureaucratic hurdles, a secretariat office called the National Health Systems Reform Office (HSRO) was set up as an autonomous agency, independent from cumbersome bureaucratic administrative procedure. The aim was to reform the national health systems through the promulgation of the "National Health Act" which would serve as the master legislative framework for new health systems. The process was expected to be completed within three years.

From the beginning it was realized that wide-ranging deliberation by and participation of the public was critical for building

consensus on various aspects of the new national health system to be established. Involvement of public, private, and civic sectors was considered crucial not only because consensus had to be achieved, but because of the strong conviction that a collective learning process was critical for reinventing health systems. This underpinning idea of public deliberation and collective learning was greatly influenced by the spirit that shaped national political reform during 1997-1998, resulting in a new constitution. The 1997 Constitution has since symbolized the transformation of Thai political ethos toward a stronger participatory form of democratic governance.

The primary goal of the reform initiative was aimed at mobilizing the broadest range of the public to actively participate in the process of rethinking and enacting the national health system. This was to ensure that changes in the health system would be in accordance with the will and expectation of the public. From professional associations, non-governmental development agencies, local community organizations, to various others in the civic sector, engagement of these civil society organizations was achieved through provincial meetings, district forums, grassroots community discussion groups, as well as regional workshops and a national assembly. These interactive learning processes to shape the reform agenda were assisted by various technical working groups and researchers coordinated by the Technical Subcommittee under the National Health System Reform Committee.

Over the past three years, dialogue on health and the health system culminated in a strong, broad-based reform movement. Recommendations and policy options to be incorporated in the national health systems reform agenda and the National Health Act were scrutinized and debated among concerned civil society organizations. Reciprocal exchanges of ideas and information between the NHSRC, its taskforces and subcommittees, and various stakeholders took place in hundreds of forums. The National Health System Reform Office (HSRO) facilitated the participation and learning processes among various

sectors of civil society in the reform process. Consensus has been reached on a great number of issues, although some complex and controversial issues are the subject of on-going debate and negotiation.

❑ The Objectives

This document reports on lessons learned from the effort to promote the role of civil society in shaping the future of the Thai national health system, a result of the research program entitled "The Roles of Civil Society and Health Systems Reform." The three year project was supported by the Rockefeller Foundation with the following objectives:

To establish coordinating mechanisms and two-way communication networks among various civil society organizations, researchers, and research institutes in order to facilitate participation and mutual learning among concerned parties on the issues of health systems reform. The coordinating mechanisms and networks will serve to mobilize and gather ideas, expertise, and opinion of various groups on the issues of health systems reform.

To conduct research on the roles and contributions of civil society to the health reform movement as well as their potential capability and possible contribution to the building of a new national health system.

To document the reform processes in order to draw lessons and experiences derived from the involvement of civil society in health systems reform movement. Lesson learned and experiences derived from the engagement of civil society in the health reform movement will be analyzed to build a framework for a better understanding of the roles and contributions of civil society in shaping the reform agenda and health action.

This report analyzes the experiences of mobilizing civil society and the health reform movement in Thailand. The aim is to provide accounts and an assessment of lessons learned during the period of the three-year reform effort (2000-2003). The roles and contributions of civil society organizations in social change have been increasingly recognized. The lessons learned and experiences gained from the health reform initiative in Thailand will contribute to a better theoretical understanding of the roles and potential of civil society in health reform relevant to low and middle income countries.

❑ Concepts and Theories of Civil Society: A Summary Review

Historical Evolution of the Concept

Before the eighteenth century, the terms "civil society" and "state" were almost synonymous (Keane 1988a: 35-38). In Europe, civil society began to differentiate from the state in the late eighteenth- and early nineteenth-centuries (Seligman 1992: 15-58). The flourishing of international commerce created a new politically active middle class in Western Europe. With gathering places such as salons and coffeehouses in urban areas and the invention of the press, a new public sphere emerged and new forms of associational life began to take shape (Habermas 1989). Prior to such political development in Europe, their compliance with state orders was the only way commoners under the ancient regime could relate to public affairs, for the state was the only legitimate actor that could claim to represent the public interest. The emergence of a public sphere and politically active middle class changed the relationship between the state and the people. For the first time, individual citizens could have autonomous ideas and distinguish their public interest from that of the state. This historical development eventually laid a firm foundation for the later democratization of Europe.

The distinctive historical context of Northern America made the development of American civil society unique. Alexis de Tocqueville observed in the early 19th century that associational life and voluntary

associations in American society were central to its democratic equality. "Americans of all ages, all conditions, and all dispositions constantly form associations," wrote Tocqueville.

> They have not only commercial and manufacturing companies, in which all take part, but associations of a thousand other kinds, religious, moral, serious, futile, general or restricted, enormous or diminutive... Wherever at the head of some new undertaking you see the government in France, or a man of rank in England, in the United States you will be sure to find an association (Tocqueville 1947: 106).

As pointed out by Barber (1995), Tocqueville's account revealed that American society of the early 19th century comprised not two, but three sectors: government, markets and civil society. Civic activities were prevalent and individuals thought of themselves as citizens and their groups as civil associations in which they worked together to achieve common good.

Current interest in the concept of civil society was stimulated by political changes and the democratization of Eastern Europe where dictatorial regimes were challenged by small, self-organized, pro-democratic groups. These seemingly diffused, isolated organizations grew into a well-connected, autonomous network that finally liberated Eastern Europe. In this political transformation of Eastern Europe, the idea of civil society was partly influenced by the political thinking of Gramsci, an Italian Marxist (see Garty, ed. 1989; Bernhard 1993; and Nagengast 1991). Departing from Marxist orthodoxy, Gramsci conceptually divided society into two parts, political and civil, and stressed the dialectical relation between them. The state, or political society, according to Gramsci, was the coercive institution of administration whose functions were based much on the logic of force. "Civil society," in contrast, was made up of those institutions, both public and private, that

relied on shared values, ideas, and meanings rather than naked force (Nagengast ibid.: 213; Babblio 1988; Gramsci 1971).

In a neo-liberal political tradition, interest in "civil society" or "The Third Sector" has grown out of the disillusionment with the government or state machinery. The nation-state, long considered the sole institution representing the nation, was challenged by complicated problems that transcend national boundaries. Eric Hobsbawm, a noted British historian, argues that, as the world entered the twenty-first century, the nation-state was put on a defensive stance against a world economy it had little power to control.

> [The] very fact that, during the era of its rise, the state had taken over and centralized so many functions, and set itself such ambitious standards of public order and control, made its inability to maintain them doubly painful (Hobsbawm 1994: 576-577).

The dissatisfaction with government has culminated in the call for "less government" on the one hand, and "reinventing government" on the other (Osborne & Gaebler 1992). Daniel Bell, a leading political sociologist, posits that "the national state has become too small for the 'big' problems of life... and too big for the 'small' problems" (Bell 1989: 55). For Bell, the demand to renew civil society is "the demand for a return to a manageable scale of social life."

While skepticism towards the state was increasing, suspicion towards transnational corporations was also on the rise. Korten in *When Corporations Rule the World* (1995) warns how global financial institutions and transnational corporations, in pursuing their wealth, could do more harm than good especially to the disempowered developing world. The distrust and discontentment towards global financial institutions such as the World Bank, the IMF, and WTO was expressed in the vigorous protests by various global civil society movements and

by organizational efforts such as: Jubilee 2000, a worldwide movement to cancel the debt of impoverished countries by the new millennium; Fifty Years is Enough; U.S. Network for Global Economic Justice, a network working to bring about changes in the policies and practices of the World Bank and the IMF; and Third World Network (TWN), which focuses on global inequality, health, and human rights.

The existence and essence of civil society has evolved greatly during the past two to three centuries. The definition of "civil society" has changed over time, reflecting changing political circumstances. What makes the idea of civil society remarkably interesting is that it is a concept shared across various schools of political thought. "Civil society" is seen as a force of scrutiny and criticism, useful as a corrective to other accounts of the good life and democratic society. The civil society argument, as pointed out by Michael Walzer (1992), "is directed as a critique of both the left (too wedded to government action in the pursuit of distributive justice) and the right (too unconcerned about the destructive impact of competitive markets on the fabric of associational life)." The general appeal of civil society derives largely from common agreement that civil society was the building block of democracy and a better system of governance (see Keane 1988b; Putnam 1993; Clark1991).

Defining Civil Society

Although there are differences among various civil society arguments, these differing theoretical orientations share common notions on the characteristics of civil society. Such characteristics include civil society as a realm of social interaction that is autonomous, voluntary, democratic, and private-for-public. Michael H. Bernhard (1993), in his book on the origins of democratization in Poland, points out that the historical evolution of "civil society" was marked by the creation of an alternative "sphere of autonomy" in the late eighteenth century. He writes:

> [This] sphere of autonomy, which I will call the "public space," was created between the official public life of the monarch, the state, and the nobility, and that of private and/or communal life. In time, a range of associations and organizations (voluntary, professionals, cultural, social, and trade union), political parties, social movements, and communication media (the press and publishing) came to populate it (Bernhard 1993: 3).

According to Bernhard, these autonomous organizations were able to organize themselves outside the official political sphere and compelled the state to recognize and respect their existence and thus radically alter power relations in the political system as a whole.

The autonomy of civil society, as its other name "The Third Sector" signifies, is defined in relation to the first two sectors: state and market. Oliveira and Tandon, in their article entitled "Institutional Development for Strengthening Civil Society", define civil society as

> [the] web of associations, social norms and practices that comprise social activity different from activities of the institutions of the state (such as political parties, government agencies, or norms about voting) or the institutions of the market (such as corporations, stock markets or expectations about the honoring of contracts) (Oliveira & Tandon, eds. 1994:6).

Bratton, building on Putnam's formulation, refers to civil society as "the sphere of social interaction between the household and the state which is manifest in norms of community cooperation, structures of voluntary association and networks of public communication" (Bratton 1994). Civil society is characterized by participatory process. "It comes into being when people construct a sphere

other than and even opposed to the state... including, almost always unsystematically, some combination of network of legal protection, voluntary association, the forms of independent expression" (Soccorso 1994: 8).

Other definitions stress slightly different aspects of civil society as important characteristics. Cohen and Arato, for instance, define civil society as "a sphere of social interaction between economy and State, composed above all of the intimate sphere (especially family), the sphere of associations (especially voluntary associations), social movements, and forms of public communication" (Cohen & Arato 1992: ix)

The Civic Practices Network offers another definition, stressing the networking aspect of civil society. "Civil society refers to that sphere of voluntary associations and informal networks in which individuals and groups engage in activities of public consequence" (Civic Practices Network, online at: www.cpn.org/sections/tools/models/civil_society.html). Civil society is," as Barber (1995) argues, "public without being coercive, voluntary without being private." Similarly, Rubem Cesar Fernandes (1994a: 343) sees civil society or the Third Sector as consisting of "private organizations and initiatives aimed at the production of public goods and services." He proposes a simple scheme to distinguish between private and public realms, adapted and shown below.

Agents		Ends		Sector
Private	for	Private	=	Market or Business
Public	for	Public	=	Government or State
Private	for	Public	=	Third Sector or Civil Society
Public	for	Private	=	Corruption

(Adapted from Rubem Cesar Fernandes 1994a: 342)

In summary, one can define civil society as *"an autonomous sphere of social interactions in which active individuals and groups form voluntary associations and informal networks and engage in activities with public consequence."*

Although the concept of civil society originated as a Western political idea, it can be used as a conceptual tool to understand the emerging "private, nonprofit organizations" or "the Third Sector," which has increasingly influenced health and social development in many parts of the world today. In forging a broad-based health systems reform movement in Thailand, civil society was situated at the center of the movement. It was a strongly held conviction that the roles of civil society and civil society organizations were crucial in creating a vigorous health system reform in which dialogue and deliberation is the key to creating a consensus of what is good for the individual as well as collective health.

❑ Research Questions

To ensure that lessons learned from the Thai health systems reform movement were fruitfully collected, the research process was designed as part of the reform and proceeded as the reform process progressed. Using qualitative research, an extensive set of research questions was formulated at the outset as a guideline broad enough to cover important theoretical issues that might be encountered as the research evolved. The research questions were grouped into three main areas as follows:

(1) On the concept and theory of civil society and health:

What is a tenable theoretical understanding we can draw from Thailand's unique experience of the civil society movement in health systems reform? How is "civil society," as a theoretical concept, understood and enacted from the points of view of various actors in the health systems reform movement? How is the concept of civil society useful in conceiving a reform movement? What is the relationship between civil society, public policies, and health reform?

(2) On the strategies and approaches to strengthen the roles of civil society:

From the understanding of the roles of civil society gained from Thailand's health systems reform experience, what strategies or working models facilitate and further strengthen the roles and contribution of civil society in health and human development? What are the strengths and/or weaknesses of civil society in the realm of health? What are the prerequisites for the strengthening of the roles of civil society in health system reform?

(3) On civil society and health governance:

From lessons learned through the participatory process, what are the critical functions of civil society in health policies and actions? How does civic engagement influence the reform agenda and reform processes? What are the roles of civil society in creating stronger democratic governance in health systems? How can civil society best contribute to the functioning of new health systems and health systems governance?

These core questions guided the study and the analysis of the reform processes. The findings from situation reviews, literature reviews, and case studies were synthesized around these research questions to crystallize the understanding of the relationship between civil society and health system reform. Qualitative research was conducted, using the following materials and method.

❑ Framework and Methodology

The research program of which this report was the result was created in parallel to the health systems reform movement. It took ideas, concepts, work processes, and examples as objects of its studies. The research procedure of this study was not a detached but a participatory process in which researchers of the program actively engaged both in continual dialogue and in action throughout the reform process. It was

our strong conviction that there would be no objective, neutral, and value-free assessment and only an epistemology based on practice and direct engagement that can appreciate as well as appraise a process aimed primarily at social change.

Research was undertaken in accordance with the way reform processes unfolded. According to the reform plan, the first year of implementation aimed at building up the knowledge base and creating an infrastructure for the mobilization of civil society in the reform movement. By the end of the first year, various forums were organized to inaugurate the dialogue on health problems among stakeholders. The issues raised in the forums were recorded and used as input for the analysis and formulation of the reform framework.

In the second year of implementation, the initial legal framework for health reform was proposed in order to begin the deliberations. Extensive debates on the proposed legal framework were encouraged. Hundreds of forums and workshops at various levels were organized to scrutinize the framework. By the end of the second year, a draft of the national health act was introduced, taking into consideration the ideas and suggestions gathered from the debates. Following hundreds of local, provincial, and regional forums, a national health assembly was organized to revise the final draft of the act. The processes of debate and deliberation were observed and documented. The third year of reform was dedicated to promoting health initiatives in accordance with the new National Health Act, which was waiting to be approved by the Cabinet and the House of Representative.

❑ Materials and Method:

At the outset, a technical working group was appointed to facilitate and coordinate on going research on civil society and health systems reform. Regular technical workshops were held among members of the working group to assess the situation, formulate work plans, conduct necessary research studies, as well as supervise on going

research and case studies. Experiences gained during the three years of engaging civil society in the health reform movement were systematically analyzed and synthesized to formulate a tenable theoretical understanding of the roles and potential contribution of civil society in shaping health policies and social changes.

Other than the reviews, interviews, and case studies, a series of technical seminars were regularly organized to discuss and develop deeper understanding of the ongoing health reform movement within contemporary Thai socio-political contexts.

The process of regular technical meetings was designed to ensure that parties involved in the reform movement had a chance to share their perspectives with researchers and to learn from their own experiences. In the final year of the program, four regional workshops were held to allow various parties to reflect upon their experience on health development and reform.

The working process of the Health Systems Reform Office has been systematically documented to reveal how an organization defined its vision, mission, and strategies in working to mobilize participation and to strengthen the roles of civil society in determining the future of health systems. It was expected that lessons learned from the experience in the civil society movement and health systems reform would provide a strong basis for synthesizing a sound theoretical understanding of the roles and potentials of civil society in health and social change in the context of lower and middle income countries.

❑ Overview of the Report

This report provides a detailed account of the health systems reform movement and ways in which civil society was engaged in the reform process. It aims to analyze and evaluate Thailand's experiences in strengthening the roles of civil society in the health systems reform movement. It emphasizes the understanding of changing roles and relationships between civil society and the state, and how these

changing roles shaped new health awareness and health practices in Thailand. The report is organized into five main parts. The second part of the report provides a historical background of Thai politics, the evolution of health systems in Thailand, the emergence of civil society and the growing roles of civil society in the domain of health care and health development. The third part reviews global experience regarding health sector reform, finding that the roles of civil society are largely absent. Civil society is absent from health care reform in a double sense-as a topic in the health care reform debate, and as an actor or political force in shaping the health care reform agenda. The fourth part of the report provides an account of the health systems reform movement in Thailand, beginning with a discussion of the guiding concepts and working strategies that emphasized involvement and mobilization of civil society to create a broad-based reform movement, and examining how the ideas, concepts, and strategies were implemented. The fifth and final part of the report looks forward and provides practical suggestions on ways and means to encourage and strengthen the roles of civil society in health and social changes. This last section also suggests some research questions for creating a better understanding and developing the potential of civil society.

2
Background: Political Development and the Evolution of Health Systems in Thailand

❑ The Political Landscape and Emergence of Civil Society in Thailand

This section explores the current political landscape and examines the emergence and increasing role of civil society in the dynamics of contemporary Thai politics. A review of political development in Thailand reveals an increasing role of the civic sector in Thai society. In fact, the Seventh International Conference on Thai Studies held in July 2001, which gathered some 700 social science scholars from around the world in Amsterdam, convened under the theme: "Thailand: A Civil Society?" Terms such as "civil society," "citizenship," "public sphere," "collective consciousness," and "civic virtue" appear in Thai discourse and increasingly are employed by social activists, media, and academicians (see Suwit ed. 1997; Anuchat & Krittaya 1999; Yuthana & Sunita 2000).

Chris Hann, in a book co-edited with Elizabeth Dunn (1996), *Civil society: Challenging western models,* follows Adam Seligman (1992) in identifying three distinct ways in which the notion of civil society is used: first, as a political slogan, powerfully employed in an ephemeral usage against the state; second, as "a positive, analytic term" for analysis in empirical research, though some view this usage as confusing and redundant, too vague and lacking strict definition; third, as a normative concept, a desirable social order employed to judge how "good" or "democratic" a society is. How the term civil society is used and how its relation to the state is perceived largely depends on socio-political and historical circumstances (Hann and Dunn 1996).

Although the meanings of "civil society" vary among different usages, the term is commonly accepted as implying new ways of political action and democratization process. Instead of viewing official politics and representative democracy as the only means for social change, the civil society movement in Thailand seeks to create alternative political spheres and strengthen the roles of people in "public politics" (see Chaiwat 2004). From grassroots community organizations to national movements, various civil society organizations are making their presence felt and trying to make a difference in people's social and political lives. The current situation in Thai politics can be characterized by an increasing public demand for participatory democracy and for increasing recognition of the roles of civil society.

This discussion first provides a historical background of Thai political development, tracing the current political situation to the commencement of the modern Thai nation-state. It reviews how a Kingdom under an absolute monarchy gradually transformed into a "bureaucratic polity" and eventually emerged as a democratic nation. Grounded in this historical context, the second part examines the evolution of civil society and the roles of civil society organizations in Thailand, ranging from elitist charities to highly diversified groups. The third part of the analysis examines the historical evolution of modern medicine in Thai society. It traces the history of medicine from its introduction by Western missionaries to its roles in the building of the modern Thai nation state. The analysis ends with a discussion of current health systems governance and the emerging roles of civil society in the field of health governance. It can be said that health was an important arena in which civil society organizations actively and successfully established their roles and their constituencies.

Part 1
Thailand: The Politics and Economy of the Modern Thai State

The reigns of King Mongkut (Rama IV, 1851-1868) and King Chulalongkorn (Rama V, 1868-1910) marked the inception of the nation-state of Thailand. The increasing pressure of the colonial powers, Britain and France, forced the royal court of Siam to cautiously transform the Buddhist kingdom of Siam into a modern nation-state. These pressures culminated in the 1855 signing of the Bowring Treaty, opening Thailand to foreign trade. Since signing the Bowring Treaty, Siam (now Thailand) has become increasingly integrated into the international order and world markets (Keyes 1987; Ingram 1971).

The transformation of Siam to nation-state brought political reform; economic changes and an augmentation of a highly centralized bureaucratic system (see Riggs 1966; Siffin 1966; Tej Bunnag 1976; Wyatt 1969). This transformation resulted in the formation of a new class of bureaucrats and eventually led to the 1932 coup led by young bureaucrats, military officers, and civilians, many educated in Western countries (Stowe 1991: 9-22). The coup transformed the absolute monarchy into a constitutional monarchy, and founded what Riggs (1966) called a "bureaucratic polity" in which commoner officials were placed in the cockpit of political power. Although the initial intention of the coup was democratic reform, democratization was hindered by the clash between civilian and military factions of government. Tension between military and civilian elements continued through 1992, with military governments predominating during much of the era of constitutional monarchy.

During the 1960s, with the Thai economy becoming increasingly integrated into the world market, state development policy promoted cash corps such as jute and cassava. Forests throughout the country were cleared for cash crops. Massive government investment in economic and physical infrastructure paved the way for modernization

of the Thai economy, culminating in the last two decades in rapid transformation of the Thai economy and the formation of a new middle class of entrepreneurs.

From a predominantly agrarian society, Thai economy has turned towards industrialization and enjoyed an exceptionally high growth rate over 20 years from 1960s to 1980s. The national Gross Domestic Product (GDP) has exhibited continuous growth averaging over 7% per annum (World Bank 1984), peaking at over 10% per annum from 1988 to 1990. This sustained economic growth was achieved predominantly by rapid industrialization, an increase in foreign investment, tourism, and a growing export-oriented manufacturing sector. Thailand's optimistic economic outlook was so promising that in 1982 the World Bank's economists published a report suggesting that Thailand, among another 12 developing countries, was a "second tier." It would likely emerge as one of the NICs (Newly Industrialized Countries), following the footsteps of the original four NICs in Asia: Hong Kong, Singapore, South Korea, and Taiwan (quoted in Tan 1993). The exceedingly rapid growth was estimated to generate a fourteen-fold increase in the national income and an average eight-fold increase in per capita income over the two decades from the mid 1970 to mid 1990s (World Bank 1984).

❑ Thailand and the Global Political Economy

Unmistakably, aggressive government policy towards industrialization was increasingly influenced by the global political economy. Under the mainstream development paradigm, Thailand's successful growth-oriented economic strategies relied heavily on foreign capital inflows and foreign investment. In 1997, the overheated economy of Thailand melted down, at the same time bringing down other Asian economies. Facing the mounting crisis, considered the most damaging since World War II, the government was forced to devalue the currency against the US dollar. The Thai government was compelled by

the severity of the crisis to enter into an economic recovery agreement, providing $ 17 billion dollars under a stand-by arrangement with the International Monetary Fund (Pasuk & Baker 1998). Although the effect of the economic downturn hit first and most intensely on the industrial and financial sectors, rural communities who had few buffering mechanisms to cushion the austerity measures imposed by the International Monetary Fund and the World Bank would eventually feel its ripple effects.

Yet the economic crisis had a positive side. As the crisis developed, it became clear that the crisis facing the nation in fact had its deepest roots in corrupt politics. The growing middle class who, over the prior two decades, had prospered as never before, saw their wealth evaporating in front of them, vigorously demanded political reformation. Middle class white-collar workers gathered in the streets demanding political change. The new constitution drafted by an independent assembly, despite proposing various progressive measures which would cripple the power of those who presently enjoyed their political privileges, was approved by the national House of Representatives. This new constitution, dubbed the "People's Constitution," provided for drastic change in the Thai political landscape and began a new era of citizen's participation and deliberation in political affairs.

❑ A New Political Ethos and Emerging Civil Society

The emergence of civil society as a social institution and the relationship between civil society, political society and corporate society is historically contingent. The development of a civil society in Thailand, a country typified a relatively evolved state formation without concomitant development of civil society. However, the last decade has witnessed drastic changes in the Thai political and economic scene. Rapid economic growth has accelerated and increased the role of the middle class in Thailand.

In the May 1992 political upheaval, the middle class gathered and protested against the military junta, and eventually cast out the coup leader from the premiership. News reporters called the protestors the "mobile-phone mob," marking both the social class of the demonstrators and the means of communicating the situation to their friends and families. Previous descriptions of Thai society as a "bureaucratic polity" have been challenged by Anek Laothammatas, who posits that the Thai state has transformed from a bureaucratic polity into a state of "liberal corporatism" or "social corporatism." Such a transformation was marked by the emergence of a powerful middle class in Thai politics and the consolidation of economic sectors (Anek Laothammatas 1992).

Coinciding with Anek Laothammatas' analysis, Thirayuth Boonmee, a prominent social activist, proposes a ground breaking analysis of Thai politics and suggests a strategy for social change which takes into account a crucial role of "civil society" (Thirayuth 1993). He points to an emerging civic consciousness, expressed in the popular and professional movement in the last few decades. This movement, according to Thirayuth, is more diffuse in character, emphasizing popular involvement rather than highly centralized, hierarchically organized movements as were popular among socialist-minded activists during the 1960s and 1970s. This civic movement is also characterized by the emphasis on local initiatives and the empowerment of organizations outside the realm of the state such as NGOs, business firms, and professional organizations.

According to Thirayuth, the existing national ideological construction of the "nation," which has been employed by the state to promote nationalist loyalty and social cohesion, has lost its compelling power and become irrelevant. Thirayuth contends that "civil society" has been emerging as an ideological construct replacing the old nationalist construct. The ongoing process of the institutionalization of "civil society" will eventually foster further development of Thai politics. Thirayuth spells out four steps towards the strengthening of

civil society, which include the emergence of collective consciousness at the societal level, the formation of various civic organizations, the crystallization of civil society as an ideology, and the institutionalization of civil society. Thirayuth suggests that in the last three decades, Thai society was in the third step, where "civil society" was emerging as a new political ideology.

Part 2
The Emergence of Civil Society in Thailand

❑ Historical evolution of Thai civil society

Thai historical accounts indicate that the principal non-state actor in pre-modern Siam. was the Buddhist Order, or the Sangha, the center of social and moral life. Buddhist monasteries around the country brought people together to engage in collective life. Not only religious activities in terms of merit making and ritual ceremonies, but also various other cultural and charitable events took place in the monasteries. Most rural monasteries played important roles in providing education-religious, secular and occupational.

Other than the Buddhist monasteries, early philanthropy was organized by members of the royal family. In 1890, the National Red Cross Society was established by Queen Somdej Phrasripacharindhra, in the reign of Rama V . The first orphanage was also set up in Bangkok by a member of the royal family.

In addition to these royal initiatives, there were also a variety of ethnic and religious organizations. Most prominent were Chinese clan associations. They provided necessary food, accommodation, medical care and social welfare for Chinese immigrants. Some of the earliest hospitals established in Thailand were started by Chinese philanthropic associations (Thienfa Foundation Hospital and Huachiew or Chinese Oversee Hospital, for instance). In addition, other religious groups also sought to provide humanitarian aid. Western missionary groups also came to the Kingdom and set up hospitals-the McCormick Hospital in Chiang

Mai, the first hospital in the Kingdom, and Bangkok Christian Hospital and the Mission Hospital among the early missionary efforts to render medical assistance to local people. These efforts were particularly prominent after World War II.

The civic sector in Thailand evolved in three phases. The first phase spans the post-World War II military era. The second phase of democratic struggle ended in 1991 when the pro-democratic movement brought down the last military regime in Thailand. The third period surrounded the drafting and promulgation of the 1997 "People's Constitution" (Amara 2002).

First Period: Post-World War II Military Era

Most of the non-profit organizations during this time confined their roles to social services and charitable activities. There were only a small number of such organizations, mostly run by the elites of Thai society. These organizations provided support and services for disaster victims, scholarships for poor students, and donations to hospitals for the disadvantaged. There were also a number of Chinese clan associations whose roles were to provide support among clan members. Some of the Chinese clan associations were viewed with suspicion by military governments, for alleged association with and influence by the Chinese Communist regime. Local Buddhist monasteries played an important role in providing support for the destitute. A few other religious groups existed and played limited roles typically among their small circles of followers.

Second Period: The Era of Political Struggle for Democracy

In the early 1970s, the pro-democratic movement, which had gradually gained political momentum and popular support, posed an unprecedented challenge to the military dictatorship. A student-led uprising on October 14th 1973 ousted the military junta and opened up a new era of political participation and democratization. A variety of

people's organizations emerged including labor organizations, farmer associations, and student organizations. The active political movement came to a standstill after an October 1976 crackdown and massacre. It was not until the end of Cold War that people's organizations began to flourish again.

The period of the 1980s saw a surge in the number of non-profit organizations. This growth coincided with the commencement of interest and policy emphasis on rural development. A number of organizations began work in community development and gradually expanded to concerns regarding the environment, children, and health. The advent of the "Primary Health Care Movement," contributed greatly to the increasing role of civil society organizations in Thailand. The policy's emphasis on people's participation and integration of health and social programs provided legitimacy to community's collective action and the involvement of non-state actors in the implementation of health development projects.

Third Period: The Emergence of Strong Civil Society

Thailand in the 1980s experienced rapid economic growth and industrialization. Thai economic expansion spurred the growth of the middle class in Thai society. Business associations became increasingly assertive and eventually exercised strong influence in government policies. When the subsequent 1991 military coup was perceived as detrimental to democratic principle, the middle class hit the streets in one of the biggest protests in Thai history. The military junta was then ousted and a civilian government set up. With a fresh memory of political resentment, pressure for constitutional reform began in 1994. Reform attempt in the fields of health, education, media, and power de-centralization was also initiated, but to no avail. The resistance to change was strong. The following half decade witnessed extraordinary economic performance, ending with the 1997 financial crisis.

It was not until the Thai economy collapsed in 1997 that

reform movement gained its impetus. The crisis had weaken opposition to reform while the call for new system of governance became stronger. Middle class, white-collar workers gathered on the streets demanding political change. A new constitution was drafted by an independent assembly. In the process of drafting the new constitution, civil society became involved nationwide. Community organizations, NGOs, and concerned academicians, from the grassroots to national organizations, joined hands and created forums to deliberate on the new architecture of democratic governance. These civil society organizations became strong change agents, forging a new political sphere, a sphere of deliberate citizenship in which the voices of the excluded could be heard and extreme asymmetrical power relations could be more effectively challenged. Despite progressive measures which would cripple the power of those enjoying political privilege, the Parliament approved the proposed Constitution, bowing to strong public pressure.

Part 3
Thai Health System and the Evolution of Modern Medicine in Thailand

The following analysis demonstrates the relationship between health, medicine, the state, and civil society, as it has evolved in Thai society. The analysis does not aim to be an exhaustive review of Thai medical history. As will be demonstrated, the current system of national health governance resulted from the interactions of multi-leveled historical forces, representing competing groups, each with its own agenda. From the early days of colonial expansion to the age of globalization, the interplay of medical knowledge, professional authority and the state influenced and shaped society's health as well as its power structure.

While the colonial powers employed medicine as an instrument of control and domination, medicine was also appropriated and employed by the state to lend legitimacy to its expanding role among

the public. In the development era, illness and disease became a rationale for the increasing role of the state as the champion of development. Medicine and health care were at the top of the developmental agenda of most developing countries. While medicine and health care were used to legitimize and extend the power of the state, poor health and the unequal access to medical care prompted the desire for equality and social justice. Medicine was therefore as much an institution for social control as a realm of competing political action. It will be clear by the end of the analysis that, in the context of emerging civil society and civic politics in Thailand, health has become a strongly contested domain in the nation's transition from representative democracy to a more participatory form of democracy.

The first part of the following discussion examines the historical evolution of modern medicine in Thailand. It traces changes and transformation of medicine and the health system since pre-modern Siam to the establishment of western medicine in the modern Thai nation state. It details how the current health system governance results from a long evolutionary process, the specific socio-political context surrounding that evolution, and the influence of the changing context of current Thai politics. The analysis then examines the health situation in Thailand. Although many health indicators have improved in the last three decades, the emergence of non-communicable disease and new infectious diseases, health impacts from development policies, and health system governance have become new challenges. The analysis concludes by examining how health has become a major sphere for civic communities and civil society to realize their political autonomy and to achieve active citizenship. This analysis provides the contextual background to better understand the health systems reform movement in the following chapters.

❑ Historical Evolution of the Thai Health System

Health and Medicine in Pre-modern Siam

Prior to the introduction of western medicine into the kingdom in the 19th century, the traditional health system of Siam was an eclectic mix of multiple indigenous healing traditions (see Suwit & Komatra eds. 1987). Systemic knowledge and practices of healing existed only among *"mau luang"* or the house doctor of the royal court, while commoners generally relied on *"mau chalueysak"* or local healers whose knowledge and skill was more of a wise person than of a professional. The ideas of public health and an organized system of health care were inconceivable under the traditional system of knowledge and social organization. In ancient pre-modern Siam, the roles of the sovereign were confined primarily to the protection of its subjects from external intrusion. With regard to internal affairs, state apparatus was developed and employed only in so far as it was necessary to ensure loyalty, taxation, and social order.

To better understand how medicine and health care played a role in pre-modern Siamese lives we need to look into the pre-modern social organization of the Kingdom. The socio-political organization of pre-modern Siam was characterized by the *sakdina* system, a system of ranking in which the entire population was organized hierarchically. The system drew the dividing line between two major social strata: "upper class person" and "lower class person". The small ruling stratum accounted for no more than 2,000 persons out of an estimated population of two million during the Ayutthaya period (Chai-anan 1976; cited in Turton 1980: 253). Among the royal family and courtiers, the royal doctors *(mau luang)* were available for treating ailments with various forms of traditional medicine. Commoners, or the lower class persons, relied on folk doctors *(mau chalueysak)* to deal with their health problems. The state played little role in everyday health and medical problems.

Only when there were massive epidemic outbreaks that threatened peace and security did the state take on an active role. Certain ritual ceremonies were performed to ward off epidemics, which were conceived as attacks by evil spirits (Pensri 1985). Although no system of health care was organized for commoners, the royal court played an instrumental role in gathering and systematizing medical knowledge. Medical knowledge was inscribed and displayed for the public (see Vichai 2002a: 56-58). With a limited role of the state in public health, most health problems were taken care of by families and communities relying on home remedies and traditional medicine. Early missionary records indicated that households relied on a variety of indigenous healing practices, such as midwifery, herbal medicine, massage, and spiritual healing (Bradley 1865; Beyer 1907; Mcfarland 1928).

Medicine and the Colonial Encounter

Although western explorers arrived much earlier, it was during the reign of King Mongkut (Rama IV, 1851-1868) and King Chulalongkorn (Rama V, 1868-1910) that colonial involvement reached its greatest intensity. By the latter half of the nineteenth century, European powers were aggressively pursuing their colonial conquest in Southeast Asia. Siffin describes the Siamese situation in the nineteenth century:

> With Burma humbled by Britain and with British authority established at Penang and the Straits Settlements, with the China ports smashed open, the surge of Western activity posed a growing threat to the security of Thailand (Siffin 1966: 46).

It was within this colonial context that Siam undertook modernization. Colonial Britain was forcefully making its way into India, Burma, Malay, and parts of China, while the French were penetrating

Vietnam, Cambodia, and Laos in an even more aggressive and belligerent manner. Modern systems of knowledge and institutional practices such as historiography, medicine, architecture, astronomy, and archaeology were part of colonial practices (Asad 1973; Bhabha 1985; Stocking 1987). Medicine and missionary doctors occupied a special place in the history of the colonial encounter, for medicine was the technology par excellence for proving the superiority of western colonial knowledge.

One of the most important medical doctors who came to Siam during the reign of King Rama III was an American missionary, Dr. Dan Beach Bradley. Keen to introduce various western technologies to the Kingdom, Dr. Bradley was the first to establish and run a printing press in Bangkok. His periodical, "Bangkok Recorder," became a public medium that spurred scientific debate among the Siamese elite. He also introduced vaccination and demonstrated modern medical surgery by amputating the arm of a monk who had been seriously wounded by a fireworks explosion. Although it was a successful operation and modern medicine was increasingly appreciated by local people, it was not until the reign of King Rama V, or King Chulalongkorn that the first medical hospital under royal patronage was initiated: Siriraj Hospital, established in 1888. This opened up a new chapter of medicine and health development in Thailand.

In addition to establishing a modern medical facility, other health interventions were also initiated during the reign of King Rama V, as modern knowledge of health and medicine became increasingly accepted. Immunization for smallpox was introduced while various laws and regulations were promulgated to ensure public hygiene and sanitation. A new department was set up in 1888 to administer public health and medical affairs. Together with the establishment of Siriraj Hospital, a medical training program was initiated. In the early period, Siriraj Hospital and the medical school incorporated both western and Thai traditional medicine. During the 1890s the role of modern medicine

was still limited. Fifteen years later, in 1907, traditional medicine was removed from Siriraj Hospital and the medical school curriculum because of the alleged lack of standardized practices and conflicts between western and traditional doctors.

The introduction of modern medicine in Thailand, together with colonial pressure, resulted in expansion of the role of the state in the provision of medicine and health care. Colonial knowledge and power transformed the traditional system of sovereignty into a benevolent state, at the expense of neglect and abandonment of traditional medicine. The health care system has consequently become the domain of biomedically-focused western medicine.

Medicine, Modernity, and the Nation-State

Three decades after the founding of Siriraj Hospital, a Rockefeller Foundation representative, Dr. V. G. Heiser, passing through on his travels to China, was asked to visit and comment on the Siriraj Medical School. His straightforward answer that "... it was in the most appalling state ever seen..." prompted King Rama VI, who was educated in the West and regarded himself as the champion of the modernization of Siam, to make radical changes to the Kingdom's health care system. These changes not only affected how health care was organized but also marked the beginning of professional medical authority. The first licensing bill for the medical profession became law the following year, 1923. Through Prince Songkhla, who was residing in the United States at the time, Prince Chainat, overseer of the medical school, requested assistance from the Rockefeller Foundation to upgrade the medical school to meet international standards. The Rockefeller Foundation agreed to assist in improving the medical school if the government agreed to invest in creating a professional career structure and suitable infrastructure so that graduate doctors could work in a good hospital-based environment. When these conditions were met, the Rockefeller Foundation poured in resources continuously for thirteen

years, making it one of the biggest assistance programs ever to create professional careers for doctors (Chanet 2002).

With the establishment of the medical school and a high quality medical hospital under Royal Patronage and assistance from the Rockefeller Foundation, medicine in Thailand became a prestigious profession and held unbridled power over health and health care of the country. It can be readily seen that under the professional authority of the medical establishment, the biomedical worldview was soon to become dominant in health development discourse.

The establishment of modern hospitals was not widespread prior to the 1932 coup led by young bureaucrats (Bamrasnaradur 1957). Early statements made by the coup leaders stated clearly the goal of expanding health care to the larger population in accordance with the democratic principle of equity.

The role of medicine in nation building was most evident during the Phibulsongkhram regime. Marshall Phibulsongkhram put great emphasis on the development of medical care and public health in his policy statements (see Rong 1977). His aim was to build Thailand into a great nation state comparable to western super powers. He saw health care as part of enhancing both the quality and quantity of the population. He organized ballroom dancing to promote marriage among single people, provided incentives for couples to have more children, and built the Women's Hospital and Children's Hospital to ensure that mothers gave birth safely and that children survived. Phibul, as he was known, also imposed "state conventions" on people's behavior such as eating nutritious food, personal hygiene, sleeping habits, and physical exercise. Using modern medicine as its basis, Phibul's plan was to increase the Thai population from 18 million to 40 million. His speech at the ceremony establishing the Ministry of Public Health stated this idea clearly.

> A nation consists of some hundred thousand households, depending on whether it is a great or a small nation according to the size of its population. If a nation has only a small

> population, it is a small nation... The first step of making a great nation is to increase the population....
>
> Nation building depends in part on public health. Because the more public health and medicine progress, the stronger our nation will be. The population would increase in both quantity and quality... Presently we have only 18 million population, or 36 hands for work, which are too little for building a nation. If we have 100 million population, we will have the power of 200 hands to work. This will make our nation a great super power (Bamrasnaradur 1957: 62-63)

Medicine played a critical role in enforcing the power of the state in the process of nation building. The use of medicine as a political tool for Phibul's nationalist movement necessitated the centralization of the health care system. As a result, medical institutes came increasingly under the patronage of the state far more than was the case under the absolute monarchy.

Health and the Development Paradigm

Following World War II, international politics were transformed by the confrontation of capitalism and communism, with greatly expanded roles of the nation-state. Following the success of the "Marshall Plan," an international project called "development" was conceived. "Development" became the purpose of the state, particularly for third world, or "developing" countries. However, this development discourse, to a certain extent, has been criticized as an attempt to cover up political inequality and asymmetrical power relations. James Ferguson, for instance, maintains that development was discursively constructed as an "antipolitic machine" working to cover up the political root cause of poverty and suffering in Nepal (Ferguson 1994). It disguised and redressed the problems of power relations and exploitation as a lack of

development. In this development discourse, health featured prominently among development domains. Developmental discourse in the field of health reached its peak during the primary health care (PHC) movement, which by the end of the 1970s became a global development agenda (WHO 1981).

Thailand was one of the many countries in which serious attempts were made to implement primary health care policies. Village health volunteers and village health communicators were set up in most villages in Thailand. At the peak of policy implementation, the Ministry of Public Health deployed more than 50,000 village health volunteers, and approximately 500,000 village health communicators (see Thavithong et al. 1988). Eight elements of comprehensive primary health care were strongly advocated by various international organizations such as the World Health Organization and UNICEF. The eight elements were later expanded into ten elements in Thailand, including nutrition, health education, clean water supply, sanitation, immunization, prompt treatment of common diseases, availability of essential drugs, maternal and child health, mental health and dental health. The latter two were added later as they were found to be common problems.

A number of evaluations of primary health care examine how village health volunteers and various groups were set up to conduct development activities during the heyday of primary health care (see Thavithong et al 1988; and Morgan 1993). The roles of these community organizations were mostly to cooperate with health agencies in implementation of health activities. They had a very limited role in the decision-making process to determine both what was to be done and how implementation should be carried out. Rather, they participated in prearranged activities based on a universally standardized primary health care handbook.

It can be said that the primary health care movement has successfully created new, albeit limited, social spaces in which laypersons can play certain roles in health development. Instead of

viewing the public as passive recipients of health services, the policy and its implementation permitted laypersons and communities to partake in various development activities to improve their health. Participation, however, was permitted only insofar as it did not hinder policy decision-making. In other words, it was participation in the implementation processes rather than in the political processes of deliberating and determining how to improve health. Despite various interpretations of the primary health care movement from various political perspectives, in hindsight, people's participation in primary health care was conceived and executed as "implementation without deliberation."

Part 4
Health Governance and Civil Society

❑ Current Situation of Health and Health Governance

Thailand has made considerable progress in health development, based on health indicators and epidemiological transitions. A remarkable decline in the population growth rate and gradual rise in life expectancy triggered the Thai demographic transition. The demographic transition is evidenced by the shift from a broad-based, pyramid-like Thai population age-structure in 1970 to a columnar-based form. Thailand's infant mortality rate declined from 125 per 1,000 live births in 1960 to 26.1 per 1,000 in 1996, indicating a remarkable improvement (Ministry of Public Health 2001: 3). However, an obvious disparity exists between the urban sector (27 per 1,000) and rural sector (41 per 1,000) (Yongyuth & Somsak 1993).

Thailand also experienced epidemiological transitions. Infectious and parasitic diseases, as well as nutritional deficiency, have dropped sharply. The Expanded Program for Immunization (EPI) has succeeded in decreasing incidence of diphtheria and tetanus neonatorum. Tuberculosis and malaria ceased to be major health threats. Although infectious diseases were no longer the leading causes of death,

diarrheal diseases and respiratory tract infections still lead among illness that bring people to health facilities. Post-transitional problems of non-communicable, chronic degenerative diseases are emerging as a new threat to the health of the nation. Accidents, cardiovascular disease, and neoplasm were the three leading causes of death in Thailand (Ministry of Public Health 2001). The public health problems of highest concern in Thailand currently are the re-emergence of infectious diseases such as tuberculosis, malaria, filariasis, Dengue, and leptospirosis and other newly discovered diseases such as SARS and Avian Flu (see Vichai 2002b: 312). Occupational and environmental related health problems were also on the rise (Ministry of Public Health 2001).

During the mid 1980s to the mid 1990s, the spread of HIV infection in Thailand emerged as the greatest threat in the history of Thai public health, and contributed to the resurgence of tuberculosis. Thailand was one of the most severely afflicted areas, described as the epicenter of the AIDS epidemic in Asia. Thailand, to a large extent, has been successful in the containment of the AIDS epidemic due to an extraordinary concerted effort among state agencies, non-governmental organizations, and grassroots community organizations. The AIDS epidemic spurred a tremendous increase in the number of non-governmental organizations working at all levels in the response to HIV/AIDS. The effort by non-governmental organizations to reach the marginalized and to fight against social stigma of people living with AIDS has been widely recognized (see Lyttleton 2000: 116-119).

In 2001, the government of Prime Minister Thaksin Shinawatra introduced a universal coverage scheme for health care. More than 40 million people have since registered. The scheme provides a basic benefit package for all Thai citizens. Although it has helped to increase equality and access to medical facilities for those who had been left out in the past, the scheme cost the nation 31 billion baht. In addition, as the scheme focused principally on reforming the country's health care

system, priority was given to the financial and curative aspects of medical care with less emphasis on other dimensions of health. Overemphasis on the biomedical model of health and concern over cost-effectiveness made it impracticable for laypersons and non-professional organizations to participate in the reform effort. If health was defined more broadly than access to medical treatment, it would be possible to envision the active participation and lively deliberation of a broader range of actors.

Although medical facilities, curative services, and disease prevention have been highly developed in the Thai health system, health promotion has lagged in comparison. The Ottawa Charter's five main areas of health promotion activities have been slowly and unevenly developed. At the personal and community levels, various measures were relatively successful since the implementation of primary health care. However, interventions at the national level, such as the attainment of healthy public policies, were ineffective. As the nation moved toward rapid industrialization and urbanization, the impacts of development policies and projects could be felt in every facet of life. Reports of factories releasing polluted water, chemicals, air and noise pollution have been repeatedly recorded. Mega-development projects such as dam construction and industrial estates have become not only important sources of health problems but also of social conflict and violence.

❑ Thai Health System and Its Governance

From the historical evolution of Thai politics and health system discussed above, we can readily draw a number of conclusions. First, it can be clearly seen why the current health system of Thailand was heavily constrained by curative medicine and biomedical models of health. The strong support from the state and the influence of the Rockefeller Foundation helped to create a solid foundation upon which allopathic medicine was established (Chanet 2002). The domination of

curative medicine has been evident from the very beginning of the modern history of Thai medicine.

In 1924 Prince Songkhla, the father of the current King of Thailand, attended a meeting to reorganize medical education. Prince Songkhla had just graduated from Harvard University with a degree in public health. Because he was not qualified as a medical doctor, he was ridiculed by medical doctors for making comments on health policy. The incident prompted him to leave Siam, return to the United States to further study medicine, and become a medical doctor. Prince Songkhla was later named the Father of Thai Modern Medicine. The incident suggests that very early in the history of medicine in Thailand, medical doctors were an exclusive social class. As the professional authority further consolidated, medical doctors held absolute power regarding how health systems should be organized. This professional sovereignty set the stage for succeeding developments in which Thai health systems have been heavily dominated by the biomedical perspective, which has permeated the entire society in less than half a century.

It should be noted that the biomedicalization of the Thai health system was also in part determined by the decision made when the health care system was first started. There were two different views on how the health care system and health manpower should be created. The first view was proposed by an advisor from the Rockefeller Foundation to produce few medical doctors from medical school with the highest standards, comparable to those in the West. The second idea was to create more medical doctors capable of using appropriate levels of technology and more accessible by the public. Although there were a few strong advocates for the second idea, eventually the first idea, emphasizing the standard of excellence, was adopted (Wariya 1984). Such a policy set the trend of advanced biomedical standards, available to the privileged, at the expense of equity and accessibility. It also gave strong legitimacy to professional authority as the overseer of technical standards in medical advancement.

The rise of professional authority was closely tied to the consolidation of bureaucratic power. The bureaucratization of development made the official policy process more exclusive. Furthermore, medicine and health were largely employed instrumentally to accentuate and legitimize the state's power to control its citizens. This was particularly prominent during the Phibulsongkhram regime when reproductive health was stressed to achieve nationalist policies to increase the population (see Kongsakol 2002). In addition, during the height of the Cold War in the 1970s, medicine and health programs were employed by the Thai state to secure its authority and legitimacy in the borderlands (see Komatra et al 2004). From the early days in Siamese history when the state played a limited role in providing medical care and health welfare to the populace, medicine and health development has become a prominent mission and rationale of the state. Professional authority was, therefore, a crucial source of legitimacy of the state's power.

Biomedicine dominates the existing health system. The biomedical paradigm defines health in accord with biomedical perspectives and thus focuses mainly on disease and biological interventions. This predominantly reductionistic view has practically precluded interdisciplinary efforts in achieving health. Once health is interpreted strictly using the biomedical model, disciplines other than biomedicine are rendered irrelevant. Psychosocial and spiritual dimensions of wellbeing, for instance, have been ignored. In such a paradigm, involvement of stakeholders outside the domain of medical professional is unlikely. From a civil society perspective, however, health must be understood as the result of collective deliberation and action, not the sole responsibility of medical experts.

Health system governance in Thailand has relied exclusively on official structures and bureaucratic policy processes. The bureaucratization of health made health development an exclusive domain of the medical professional and public health bureaucrats.

Despite an increase in the number of civil society organizations engaged in health development issues over the past two decades, the extent to which these organizations were able to have any impact on the policies and practices of state development mechanism has been limited. The health bureaucracy in Thailand was characterized by a strong centralized planning system in which communities and civil society organizations were expected to collaborate with the pre-determined policies and projects. Even during the height of the primary health care movement, the idea of public participation was more "people cooperation" in the implementation of state ideology rather than people contributing to political decision-making on how their health predicaments should be interpreted and addressed.

❑ Emerging Roles of Civil Society in Health Governance

Although the emerging role of civil society is a recent phenomenon, civic traditions and philanthropy took root early in Thailand's modern history. Health was an important domain for such activities. The Thai Red Cross Society, for instance, played an important role in taking care of war victims. The royal orphanage also concerned itself with the health and well-being of orphans. Various elite housewife associations during the 1980s worked not only to promote high culture among their members but also provide health care and welfare for the destitute (Benjamas & Suraphol 2002: 16). During the 1960s development era, non-state actors actively engaged in various fields of development especially in the field of health. The United Nations declared "the Decade of Development" and, with the financial and technical assistance of first world nations, particularly the United States, supported development agencies and volunteer organizations to work on community development programs.

Of particular importance was the Population Development Association that contributed greatly to family planning and population control. The rural development initiative by Dr. Puay Ungphakorn was a

significant chapter in the role of civil society organizations in development. The integrated approach adopted by the project helped to place health problems in context. It was during this Decade of Development that civil society organizations working in the field of health multiplied. Most of these organizations worked with local communities at the grassroots level. A number of them have been active in the field of health, providing health care to the poor, running child survival programs, advocating the use of herbal medicines and indigenous healing, as well as encouraging organic farming and alternative agricultural practices as a healthier way of life.

Some high profile non-governmental organizations worked at national level. A number of consumer groups were extremely active, working both in consumer education and consumer rights advocacy. Also greatly noticeable was the anti-smoking activist group, which has been exceptionally successful in its campaign. In addition, professional associations were more active and played important roles in the field of health development. The Rural Doctors Association, the Community Pharmacist Association, and the Network of Community Health Workers, for instance, have been working to encourage professional contribution to the health of the poor, particularly in rural areas. These organizations engaged in public policy processes in various ways including public education, running campaigns on specific issues, advocating legislative changes, as well as working as political watchdogs (see Suwit ed. 2003).

During the 1980s and 1990s, economic expansion created a growing stratum of middle class in the business sector. A number of organizations in corporate society were increasingly active in initiating programs for public service. Examples of such programs are *Krongkarn Ta Wises,* a campaign for better environment; Think Earth Project; Central Department Store's strong support for anti-smoking campaign; Creative Media Foundation with strong support from Bang Chak Petrochemicals; and Population and Community Development

Association's Thailand Business Initiative for Rural Development project (TBIRD). Most of these initiatives could be said to be concerned with health in a broader sense. Although some were viewed as thinly veiled public relations ploys to create a good commercial image, quite a number of them sincerely address social issues.

The roles of civil society organizations have been increasingly diversified in the past three decades. In addition to providing service and support for those in need, non-governmental organizations gradually expanded their role and work in protection of rights and advocacy, knowledge generation, as well as provision of alternatives. Tobacco consumption control, environmental preservation, consumer protection, as well as promotion of alternative health have been the main areas in which civil society organizations take active roles. One of the most important events in the recent history of civil society was the eruption of the 1998 scandal in the Ministry of Public Health about over-pricing of drugs and equipment sold to public hospitals. The scandal was brought to the attention of the media and the public by the Rural Doctors Society and other non-governmental organizations.

The exposure of corruption brought about a critical awareness among concerned parties of the deep-rooted cultural practices that made possible the largest scandal in the history of the Ministry of Public Health. Media coverage was extensive. The ex-minister of public health was subsequently sentenced to jail for his wrongful conduct. The Rural Doctors Society and other NGOs have been praised for their courageous conduct in exposing corrupt administrative practices. Although the public interest was eventually protected, the task of achieving structural change in public health governance to prevent repetitive fraudulent conduct will not be easily accomplished. The role of civil society organizations in creating a transparent and participatory process of health governance has been increasingly recognized.

3
A Review of International Experience on Civil Society in Health Sector Reform

❑ Health Sector Reform and the Absence of Civil society

This section examines why civil society has been largely missing from health care reform. Although civil society has become a vital social force in shaping various domains of public policies in the past decade, it has strangely disappeared both as a topic in the debate about health care reform and as an actor in shaping health care reform agenda. The chapter maintains that the absence of civil society in health sector reform is due not only to political reasons but also to the way we think about health in our modern culture. How health was conceptualized precluded the roles of civil society and inhibited it from effectively participating in health policies process, and particularly in the health care reform debate.

The incursion of civil society into the health reform affairs could be perceived as a threat to the prevailing power structure in health care politics. The health care industry has been dominated by the medical profession, pharmaceutical companies, state bureaucracies, and the insurance industry. In developing countries, state bureaucracies and medical professionals, often under the cloak of state officers, have had the dominating influence over public policies on medicine. Within this existing power structure, it is unlikely that civil society would be welcomed to participate as a significant actor in the field.

It is clear that there were political reasons for the absence of civil society in health care reform, but there could also be cultural reasons behind the obvious political explanation. The review of international experience on health care reform suggests that cultural characteristics of the reform process inhibited civil society from playing greater roles in shaping the reform agenda. These cultural barriers were

deeply rooted in the conventional perception of health and in the unquestioned framework of health sector reform. Health has been defined strictly within a biomedical framework, while the strategic task of reform has often been narrowly conceived as merely the changing methods of health care financing and improving the accessibility of medical services.

Within this interpretive framework, economics and biomedicine define the rules of the game. Decision-making in the reform of health care system is restricted to those who know economic and biomedical languages. Such a framework leaves little space for the roles of civil society as a partner in determining desirable health systems or as a potential contributor in building society's health and well-being. To create a broad-based health reform movement, it is therefore crucial to begin with an open platform that encourages public deliberation rather than a rigid framework that restricts political participation and restricts the role of the public at large.

The following review is divided into two parts. The first part examines the emerging roles civil society has played in health and human development in the past decade. With the increasing roles of civil society as background, the second part examines the strange disappearance of civil society in health care reform. Dominant approaches and practice in health care reform are critically examined to reveal the reasons for the absence of civil society. A few exceptional cases of health sector reform with strong involvement of civil society are discussed as possible alternative approaches.

❑ The growth of civil society organizations

The growth of civil society was a global phenomenon. In the past two decades, private non-profit organizations dramatically increased in many parts of the world in developed and developing countries alike. In the African Continent, private non-profit organizations increased from 1,506 organizations in 1985 to more than 20,000 in 1994. In Kenya alone,

non-profit organizations increased from 125 in 1974 to more than 400 organizations in 1988 while in Zimbabwe the number raised from 376 organizations in 1980 to 1,506 in 1985. In the Middle East, non-governmental organizations in the West Bank and Gaza strip increased from 272 organizations in 1987 to 440 in 1992. In Jordan, the number rose from 221 in 1980 to 587 organizations in 1992. In Tunisia, the number increased more than twofold from 1,886 organizations in 1988 to 5,186 organizations in 1991.

In Eastern Europe, more than 70,000 civil society organizations were set up during 1992-1997. In Western Europe, private non-profit organizations were also growing. In 1987 alone, 54,000 non-profit organizations were established in France, while the average rate of increase of non-profit organizations in France was 10,000 to 12,000 a year during the 1960s. In Britain, the spending by non-profit organizations increased from 7.9 billion pounds in 1980 to 12.6 billion pounds in 1986, while during 1967-1985 donations for philanthropy from the private sector increased 221% in the United States and the growth rate of non-profit organizations was 160%. In addition, since 1984 more than 40,000 private non-profit organizations were set up each year in the United State (Data from Anheier & Seibel eds. 1990; Oliveira & Tandon, eds. 1994; Weisbrod 1988; and Ben-ner & Gui 1993).

Civil society organizations were not only increasing in quantity, but their influence was changing the practices of national and global enterprises. Some of these organizations were much more effective than the inter-governmental mechanism and the nation-state. Some environmental conservation organizations had much more budget than many countries. Green Peace International and World Wildlife Fund, for instance, had annual budgets of 100 million US dollars and 200 million US dollars respectively in 1992 while the United Nations' total budget allocated for environmental protection in the same period was only 75 million US dollars.

On a global level, financial support provided to NGOs from international funding organization increased almost twofold from US$3.6 billion in 1983 to approximately US$7 billion in 1990 - the equivalent of 16 per cent of total bilateral aid flows (Williams 1990; Clark 1991, cited in Farrington et al, eds. 1993: 5). A recent report by the Johns Hopkins Center for Civil Society revealed that in the United State, Europe, and Latin America, the non-profit sector has become a major economic force, employing close to 19 million full-time equivalent paid workers, and spending US$ 1.1 trillion annually (Salamon et al. 1999).

Not only the financial support for nonprofit organizations increased in the last two decades, these organizations became much more effective than many international bureaucracies. Amnesty International and Human Rights Watch, for instance, have created great impact and have already changed state human rights practices in a number of countries. Green Peace International's media facilities and communication networks were extremely effective; it even had its own satellite link. Through its extensive communication networks, the organization could send out photographs to newspapers and circulate video news spots to television broadcasting stations in 88 countries around the world within hours (Wapner 1995: 321). Their activities were publicized in international mass media as much, if not more than, any UN agency or transnational corporate.

The burgeoning role of civil society organizations at the global level has never been more prominent. McGrew points out that in 1992, some 15,000 organizations actively engaged in creating an international civic network and at the same time expanding their roles in many international forums such as the Rio Earth Summit, the Vienna Human Rights conference, Copenhagen meeting on social development, and Cairo International Conference on Population and Development. A landmark event was the global meeting on women in Peking in 1995 in which NGOs organized a parallel meeting to advocate their own agenda which received more attention from international mass media than the

UN official meeting. As observed by Bogert of Newsweek, "in the long run, the U.N. may be just a midwife at the birth of a new transnational society" (Bogert 1995: 15).

The role of international NGOs were now even more prominent and clearly critical in influencing global agenda, challenging the roles and legitimacy of the World Bank and the IMF. In The Third World Trade Organization Ministerial Conference in Seattle, the World Economic Forum 2000 in Davos, the Tenth UNCTAD Meeting in Bangkok, and the World Bank and IMF Annual Meeting in Washington, D.C., international NGOs joined force in negotiating with the global financial institutions for a more humanistic approach to economic development (see Korten 2000).

❑ Roles of Civil Society in Health Development: International Experiences

A rough estimate in 1991 suggested that most of the 10,000 to 20,000 NGOs in the South were involved in promoting health, covering a population of 100 million people in developing countries (South Center, United Nations 1996, cited in Jareg & Kaseje 1998:820). The roles of non-governmental organizations working in health and health-related field were diverse. In the early period, most voluntary associations in this field provided humanitarian medical services. Over time, NGOs evolved to perform various tasks ranging from providing basic health services, independent health and environmental monitoring, early warning, information gathering, or providing alternative solutions to health and social problems. The report of the United Nations' Commission on Global Governance, Our Global Neighborhood, acknowledges that

> More and more, NGOs are helping to set public policy agenda - identifying and defining critical issues, and providing policy makers with advice and assistance. It is this movement beyond advocacy and the provision of services towards broader participation in the public policy realm that has such significance for governance (The Commission on Global Governance, reprinted in Boston Research Center for the 21st Century 1995: 56-57).

Gill Walt suggests that the roles of civil society organizations can be roughly categorized into three groups: support and services, policy and right, and knowledge and research (Walt 1998: 4). Nyangg'oro (cited in Jareg & Kaseje 1998: 819) describes three roles of non-governmental organizations:

- Exit option refers to the role of NGOs as creating and providing parallel health, political, and economic systems. Such a role can also be perceived as providing alternative means to health, social and political development.
- Voice option refers to the role of NGOs as advocate and negotiator. NGOs with this role engage the State in dialogue for the purpose of addressing inefficiencies, corruption, and bad policies.
- The third role is to oscillate between the "exit option" and the "voice option" according to the circumstances.

By combining Walt's and Nyangg'oro's suggestions, the roles of civil society organizations in the realm of health and social development can be categorized into four: support and services; alternative and exit option; right and advocacy; knowledge and research.

1. Support and Services

These have been the original roles performed by voluntary associations. Early voluntary associations were mostly ethnic associations concerned exclusively with the welfare of their group

members. They provided humanitarian support or medical and social services. At present, the role of providing public services in many countries around the world has shifted to the state. However, the role of NGOs as service providers has remained particularly in situations where the state machinery has collapsed. Examples of such situations were the Integrated Health Program of the Somalia Red Crescent Society; the Church's health and development activities in the Democratic Republic of Congo; and the Integrated Health and Development Program in Afghanistan (Jareg & Kaseje 1998: 820). NGOs were seen as more efficient in reaching disenfranchised or hard-to-reach groups. A good example of service-based organization was Hogar de Cristo found in Santiago, Chile by the Jesuit priest Alberto Hurtado in 1944. In 1992, this "charity corporation" had 37 offices distributed around the entire country and provided daily care to about 7,200 children, 2,900 adults, and 2,000 old people. It ran an old people's village made up of 110 houses, donated by construction companies, and had 40 shelters for destitute people in 30 cities (see Fernandes 1994b: 52). Services provided by civil society organizations varied, ranging from basic welfare and health services, to information gathering, and even to help in establishing relationships and trust necessary to bridge political gaps.

2. Alternative and Exit Options

There have been an increasing number of civil society organizations working in alternative life-style and alternative health. Some of these organizations were creating parallel health systems and offering new choices for people who were not satisfied with conventional medicine. Some were not directly concerned with health in a biomedical sense but could be considered as health-related. Organic farming, environmental conservation, sustainable agricultural development, and literacy programs, for instance, could create positive health impact. Organizations that offered alternative therapy could also serve specific interest groups and provide psychosocial care or spiritual healing complementary to biomedical treatment.

3. Right and Advocacy

Rightor advocacy-based organizations are easy to identify because of their visibility in political arena. These civil society organizations attempt to change policy and practices and their influence has been increasingly recognizable. Environmental groups such as World Wildlife Fund, Friends of the Earth, Greenpeace, Conservation International, and Earth Island Institute were particularly visible and effective. On health issues, there have been a number of high-profile consumer's right organizations in many countries. The most prominent ones are Ralph Nader's consumer group and Health Action International (HAI). The latter is a nonprofit, global network of health, development, consumer, and other public interest groups located in more than 70 countries and working for a more rational use of drugs (Kim et al, eds. 2000: 408). In the Asia-Pacific region, one of the most prominent consumer right groups has been the Consumers International's regional office for Asia and the Pacific located in Penang, Malaysia. The organization was formerly known as the International Organization of Consumer Unions, or IOCU. It was established twenty-five years ago and now has its head office in London and regional offices in Malaysia, Chile, and Zimbabwe.

4. Knowledge and Research

In 1989 Ralph Nader's Public Interest Research Group (PIRG) and the Natural Resources Defense Council (NRDC) organized a massive outcry about the use of Alar on apples after a research study found that the chemical created a cancer risk 240 times greater than those declared safe by the U.S. Environmental Protection Agency (Wapner 1995:327). A massive campaign featuring these research results pressured the Uniroyal Chemical Company to cease producing Alar not only in the U.S. but also abroad.

Knowledge and information have become increasingly important in creating changes. More and more civil society organizations have engaged in research and information gathering activities. A good example of these organizations has been the Worldwatch Institute, best known for its annual State of the World report, published in 27 languages. It has also produced Vital Sign, which tracks global changes in key environmental and social indicators such as global temperature, fish catches, population growth, and military spending. It's *World Watch* magazine is distributed to nearly 100 leading newspapers around the world. *State of the World,* an annual report of the Worldwatch Institute was a textbook used in more than 1,300 U.S. colleges and university courses (see Keating 1994: 94).

The roles of civil society organizations in various aspects of health and human development are evident. Yet in health care reform, which has emerged as an important agenda for social reform across the globe in the past decade, civil society organizations have been strangely absent both as a topic in the debate on reform and as an actor in shaping the reform agenda. The following section examines why the role of civil society has been limited.

❑ Current Approaches in Health Care Reform

In most countries, attempts to reform health care system have been sparked by concerns over increasing health expenditures and the rising number of people who do not have access to basic medical care. Although the public could easily relate to the justification for reform, their participation in the reform process has been limited: the process of reform has mostly been developed and carried out by professional policy makers and politicians with little public engagement. In a number of third world countries, international organizations also played critical roles in starting and implementing the process of health care reform. Aid agencies as well as international financial institutes demanded reform as conditions for assessing aid, loan, or economic rescue package.

In most cases, the driving force of health sector reform came from above. While the preceding review indicates that health was one of the domains in which civil society organizations have been actively involved, it was quite puzzling that in health care reform civil society has not featured, neither as an active player in shaping the reform agenda nor as potential resource for creating a better health care system. To understand this absence of civil society we will look at current approaches in health care reform to see how the way health care reform was put into practice hindered the role and contribution of civil society.

Health Care Reform and Politics as Usual

Official politics was commonly perceived as the sole instrument for change in the attempt to reform health care system. Although the official political process was crucial in various regards, this conventional approach was not a guarantee of positive results. Even in countries with time-honored political systems, polarized politics and power plays could generate resistance to changes that would prove devastating to reform process. Health care systems and medical establishments have been dominated by medical professionals, state bureaucracies, pharmaceutical companies, and the health insurance industry. Attempts to change the status quo inevitably challenge the existing structure of power and thus invite resistance. Adolfo Martinez Valle (2000), in his political analysis of Mexico's health care reform, pointed out how interest groups influenced both the policy making process and the outcome of the reform effort. The restructuring of Mexico's health care failed because the Mexican Institute of Social Security successfully managed to oppose any changes that threatened its hegemony in the Mexican health sector.

Public understanding of health care reform has also helped to confine reform to the realm of official politics. The case of health care reform in the US during the Clinton administration was a good example. Clinton's pledge to reform the health care system won popular support

and contributed significantly to his victory in the presidential campaign. At the beginning, public endorsement of reform was record high (Skocpol 1995: 67). The role of civil society and the American citizen, however, ended at the election ballot box of 1992.

Once Clinton became president, health care reform turned into a political problem left in the hands of a presidential taskforce, rather than a civic question deliberated by the public. As described by Paul Starr (1995) in an article entitled "What happened to health care reform?" health care reform in the United States was highly politicized within the context of ferocious partisan politics. The Democrats were split over the health issue, while the Republicans attempted to confound any prominent issue on the president's agenda. The sharply polarized partisan politics was so absurd that it raised doubts about the possibilities for rational discussion and political cooperation among elites (Weir 1995:104).

A reform effort starting with a forty-year high public support came to a tragic end virtually by the absurdity of "the politics as usual". A nation with a great civic tradition, as indicated in Tocquilville's witnessing account, succumbed to the malaise of partisan politics. The 1993-1994 health care reform effort in the US typified the lack of civic engagement. As forcefully pointed out by Jennings and Hanson (1995),

> ... the American way of conducting public policy debate and civic discourse has failed to cope with the challenge of health system reform. The Great Health Reform debate of 1994 was, in Daniel Yankelovich's apt phrase, "the debate that wasn't" (Yankelovich 1995). The public was misinformed and frightened by the debate and finally estranged from it.

Jennings and Hanson, citing Mills (1959), went on to say, "a large majority of Americans saw serious flaws in the health care system, but their sense of 'personal trouble' was never translated into the comprehension of a 'public issue.'" It was not a coincidence that contemporary accounts of American politics as observed by keen political scientists found that, as the civic tradition in the US was on the wane, American people have become "the disengaged" (Starr 1994) and are now "bowling alone" (Putnam 2000).

Economic Discourse of Health Care Reform

A dominant motif repeated throughout worldwide health care reform has been that of economic discourse. In this discourse, health care reform is transformed into merely the reform of health care financing systems. From AAPCC (Adjusted Average Per Capita Cost) to ZSB (Zero-Sum Budgeting), puzzling technical terms and acronyms used in the economic discourse of health care reform have confounded and daunted participation by "lay people." Moreover, this discourse has equated health care with just another economic activity. According to Kaiser Permanente, the managed care company in California and Texas, health care reform was "... mostly a matter of applying what's known about payment incentives to specific circumstances." This perspective has limited the possible roles and contribution of civic organizations because it is based on the assumption of health care as a commodity provided by medical experts. Rather than viewing health care as a public commodity to be distributed, the Civic Practice Network advocates the view of health care as a public work to be shared.

> Public work means an occasion of common endeavor and shared problem-solving that involves both providers and patients, and that takes place in the context of a larger community. We have trouble seeing public work in this sense in our society, even when it is right before our eyes. We suffer from civic myopia, perhaps in health care matters most of all.

> We do not see well because we are looking through ill-fitting glasses (Kari et al. 1994)

The underpinning assumption of the economic perspective reduced the complex set of relationship within a health care system into the single axis of "provider" and "purchaser." The citizen was reduced to a "consumer" whose expected role was to maximize benefit by maintaining market choice. Again, Nancy Kari and her colleague pointed out that:

> Operating within such a conceptual framework, the recent health policy debate has been largely cast as a choice between allocation guided by government regulation versus allocation guided by a competitive market influenced in part by interests of pharmaceutical companies, hospital corporations, and private insurers. However, the underlying privatized notion of health care as a commodity that is privately consumed by paying (i.e. insured) individuals remains unquestioned... The language and assumptions that remain bounded by rights and economic goods constrain our political imaginations, narrow social roles, and conceal the civic and public aspects of health (Kari et al. ibid.)

Reductionistic Biomedical Worldview

The reductionistic worldview of biomedicine has forced health care reform to focus narrowly on the curative aspect of health. This disease-oriented approach capitalized on the sense of vulnerability and fear of the unpredictable danger of illnesses. Politically, it has been an approach guaranteed to win popular support. More importantly, it did a great service to the dominant sectors in health care system, namely medical professionals and the pharmaceutical industry, whose prime benefits came directly from curative activities. The econocentric and the reductionistic biomedical approaches in health care reform have reinforced each other. It was not surprising then that the World Bank has

shown extraordinary interest in "Investing in health." Data from the analysis of World Bank activities in the pharmaceutical sector worldwide using 77 staff appraisal reports revealed that approximately US$ 1.3 billion, 16% of the total World Bank health, nutrition and population budget during 1989-1995, has been committed to loans or credits supporting pharmaceutical activities. Most of this amount, approximately US$ 1.05 billion, has been committed to procurement of drugs and medical equipment (Falkenberg and Tomson 2000).

The concentration of reform on costs and financing thus inevitably compelled the reform process to adopt the biomedical model of health. This reductionistic view not only reduced the complexity of health and well being into merely the malfunctioning of biological process, it also individualized health by proposing a view of health as something attainable through personal undertaking. It failed to address adequately the collective aspects of health particularly critical in health promotion and prevention of diseases. A definition of health that was not predetermined by the biomedical view and that approached health from a more holistic manner would lead to a totally different approach to reform of the health care system which would necessitate the participation of civil society in the reform process. To create a civic approach to health care reform requires not only a dramatic change in the way health is defined but also changes in policy process and the conventional division of labor in the reform process.

To achieve health in a new framework needs the involvement of the whole society rather than just the reconfiguration of health care financing and accessibility of quality care. It is only by involving civil society in the process of reform that issues left out by the conventional approach such as change of health-related behavior, community's role in taking care of the sick and the elderly, change of the relationship between care providers and patient, and the redefinition of the roles of the state and citizenry, can be effectively addressed.

What we need, then, is an entirely different policy process.

We can consider the existing policy process as a classical modernist approach to problem solving. Beginning with a grand theory of health care reform, the modernist visionary proposes to reform health care system in accordance with the grand narrative of economic rationality. Arguments in reforming health care financing are deduced from a great universal theory within which the health care system and all concerned parties are constrained. Its application of the general to the particular is devoid of any experiencing life-world with which civil society can engage. In contrast to this mechanistic approach, a civil society perspective would start with the lived experiences of people and the understandings they develop in real living situations. This paradigmatic shift would better serve the dialogical nature of the reform process and free it from a one-way implementation of predetermined ideas and conceptions. A more democratic, pluralistic policy process would redirect our way of dealing with our collective well-being. As Kari et al (1994) put it:

> Throughout the 20th century, as large government agencies and corporate structures have grown, a new stratum of managers and technical specialists has emerged who draw their basic metaphors and language from science. This contemporary "culture" of professionalism, evident in most disciplinary areas, emphasizes rationality, methodical processes, and standards of "objectivity" in place of public deliberation and active citizenship. Today, experts *define* and *diagnose* the problem, *generate the language and labels* for talking about it, *propose the therapeutic or remedial techniques* for problem-solving, and *evaluate* whether the problem has been solved. There are few opportunities for citizens to learn the skills of public action, deliberation and evaluation through which ordinary people move to the center of public problem-solving and everyday politics (emphasis in the original).

❑ Rethinking Alternate Model for Health Reform

Although civil society's role in health care reform has largely been eclipsed, the absence of civil society in health care reform was not absolute. There were attempts and, to some extent, successes in making health care reform a civic question. Some efforts to enhance the roles of civil society organizations (such as the Clinton's plan to increase the role of "group" or "conglomerations of health care consumers" in neighborhood organizations and workplace as building block of new health care reorganizations) failed to materialize. There were, however, other positive examples of civic engagement in health care reform. The following section provides a brief account of the Oregon Health Decisions initiative in the United State.

The case of Oregon Health Decisions was illustrative of civic involvement that helped shape the reform agenda of Oregon's health plan. Reaching agreement on various aspects of a health reform agenda (e.g. universal coverage, a basic minimum benefits package, equitable funding, and freedom of choice) is a daunting task in any reform attempt. The critical factor that helped make Oregon health reform successful was that Oregon Health Decisions, a nonpartisan grassroots group, developed methods for getting citizens to deliberate respectfully and responsibly at community meetings about what they wanted from their health care system. The organization held hundreds of community meetings and two statewide health care parliaments in the 1980s.

These public deliberations became the heart of the reform and helped to prepare the ground for a state reform process beginning in 1989. The process was successful in that it included most stakeholders in the public deliberations. The result was that the Oregon health reform gained strong support from a broad array of local and state groups: senior and disabled, poor women and children's health advocates, medical and nursing associations, insurance companies and small businesses, and the hundreds of thousands of others who had previously

been left uninsured. (See detailed account available at www.cpn.org/sections/topics/health/stories-studies/ohd.html.)

There have been other local initiatives to forge a wider participatory process of local grass-roots communities and civic organizations in determining a desirable health care system, but such initiatives have been more the exception than the rule. As Hoffman's recent work demonstrates, campaigns for health reform in the United States were dominated by elites more concerned with defending against attacks from interest groups than with popular mobilization. Moreover, grassroots communities and civic organizations in the United States seemed to suffer from fragmented vision and be unable to connect to the bigger picture of health care reform. Civic organizations working in the labor, civil rights, feminist, and AIDS activist movements concentrated more on pressing issues and incremental changes rather than on transforming the health care system as a whole (Hoffman 2003).

4
Thailand's Experience of Civil Society Involvement in Health Systems Reform

❑ Introduction

The following section presents the concepts, ideas, and working processes of the health systems reform movement in Thailand. It will first describe the ideas behind the reform movement and provide background on the setting up of the National Health Systems Reform Office (HSRO), the coordinating mechanism for the reform. The HSRO was created by a ministerial order with two strategic objectives: restructuring institutional arrangements through legislative action, and forging a new collective health consciousness in Thai society. To achieve these strategic goals, working strategies were formulated through a three-pronged strategy known as "The Triangle that Moves the Mountain." Each component of concepts, ideas, and working processes will be discussed in detail in this chapter.

Guiding Concepts and Working Strategies

"... the structure of our current public health system is arranged to deal with diseases of biophysical origin and not with socially originated health predicament. As a result, health care has been a passive system waiting for those who have already got sick to come to get medical treatment instead of proactively reaching out to bring about health and well-being.

Health must be understood as well-being in physical, mental, social, and spiritual senses. Health, therefore, is embedded in every aspect of human and social development. Health, and not GDP or any economic outlook, should be perceived by all as a national ideological goal. Health includes

> and transcends economic development... Health systems reform therefore equals a reform of the meaning of life. In other words, a reform of how we perceived as a worthy life and what we should hold as ultimate aim of our existence."

This statement by Professor Dr. Prawase Wasi, one of the pioneers and advocates of social reform in Thailand, captured the essence of the health systems reform movement in Thailand, a movement that has been going on for more than three years. Over three years (2000-2003), the HSRO worked to engage various civil society organizations, academic institutions, public agencies, as well as political institutions to foster healthy dynamics in the health reform processes. The three years work resulted in hundred of civil society organizations participating in the process indicates that health system reform in Thailand has become a broad-based civic movement and has gained momentum. However, as will be evident in what follows, these principles and strategies were far from being passively accepted or adopted by stakeholders, rather they were contested, challenged, and altered in accord with circumstances.

The question of how to build a healthy working relationship that would enable synergy between private, public, and civic sectors has long been pondered by social theorists in various fields. Dodge (1992), for instance, studied forms of interaction and linkage as crucial aspects of intercommunity governance. Bebbington and Farrington (1992) investigate the possible ways of collaboration between governmental organizations and non-governmental organizations in agricultural development. In the field of health, which has conventionally been viewed as dominated by professional authority and highly specialized form of medical knowledge, it was extremely interesting to see how the reform processes would encourage "laypersons" to participate in health policy and to reclaim their autonomy. The following account details and analyzes the working experiences of the HSRO as the coordinating mechanism of health system reform in Thailand.

❑ Birth of the Health Systems Reform Office

In the year 2000, an order from the Prime Minister's Office announced the setting up of HSRO:

> Presently, the national health system is incapable of bringing about an acceptable level in people's health and quality of life. The situation is in discord with the spirit of the national constitution. Action should be undertaken to reform the nation's health system in order to strengthen the quality of the health system and contain cost, and to draft a bill that will be the main legislative framework for the reform.

The decree proposed a National Health System Reform Committee (NHSRC) to oversee the reform process with the HSRO as its secretarial. Although the HSRO would initially be supported by governmental budget, it was formed as an autonomous body unbound by bureaucratic rules and regulations. The mission of HSRO was stated as follows:

1. To create a collective movement focused on transforming society's thinking about health from "fixing ill health" to "creating good health" so as to achieve health for all.
2. To support academic and technical activities to create a body of knowledge on critical issues relevant to health systems reform.
3. To mobilize civil society by supporting activities which encourage participation of people, communities, civil society, and various stakeholders in critical issues of health systems reform.
4. To support and develop relevant and acceptable measures for the reform of health systems. Such measures are to be included in the national health act, which is to be drafted during the reform process.

5. To coordinate and engage political actors, state bureaucracies, and other organizations to join forces in pushing for the reform of national health systems.

The NHSRC and the HSRO were established simultaneously and were initially tasked with promulgating the national health act within three years, while an ordinary process of drafting a bill would take on average somewhere between a few months to a year. The idea behind the prolonged process of drafting the national health act was that the most important part of the reform process was not the passage of a bill through the national legislative body, but the process of deliberation. Thus the timeframe was extended, and the scope of the conceptual framework was broadened. Health was defined in a very broad sense as *"a dynamic state of physical, mental, social, and spiritual well-being"*. The health system was defined as *"a whole range of systems relative and integral to the health of the nation including all factors related to health, be they individual, environmental, economic, social, physical, or biological as well as internal factors from health service systems."*

❑ Strategic Objectives of Health Systems Reform Movement

The health system is a complex whole with multiple dimensions and multiple domains, all interconnected. In any complex system, transformative and sustainable changes can never take place simply by imposed changes and coercive structure which usually end up creating a new monstrous regime in place of the old one, or simply adding layers to the existing system, complicating programs and obfuscating goals. As Albert Einstein is often quoted saying, "We cannot solve problems by using the same kind of thinking we used when we created them." The reform of a complex social system requires a collective learning process, a process of transformative experience that will change the way health is conceived, interpreted, and acted upon.

Required changes for the new national health systems therefore consisted of two complementary components. These two components made up the objectives of the reform process.

1. The restructuring of institutional arrangement through legislative action

The first main objective of the reform movement was to bring about changes in the structure of the national health system. The new constitution and the shift towards stronger democratic governance in Thai society called for a new system of governance in all social sectors. Accordingly, the existing structural arrangement of the national health system needed to be revised for better health system governance. As revealed in the preceding discussion, existing official policy processes, relying solely on state agencies to implement the predetermined health policies, excluded civic participation and required more transparency. What was needed was a platform that would perform the deliberative function of health system governance. In restructuring the national health system, which consisted of many interconnected subsystems, legislation was needed to reorganize the existing institutional arrangements. However, it was considered inadequate to simply impose structural changes through new legislation drafted by commissioners and experts working behind closed doors. Changes in the institutional "hardware" needed an accompanying change in society's "software" to make the reform complete. A second component was therefore needed to complement structural changes.

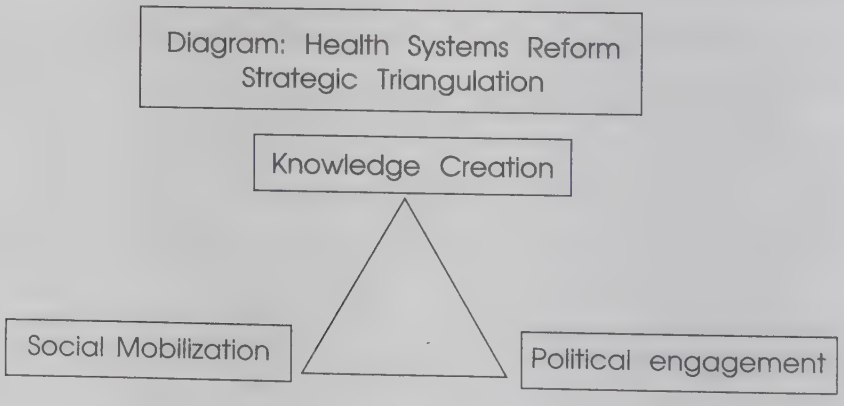
2. The forging of a new collective health consciousness

Society's approach to health depends greatly on how health is collectively understood and imagined. In the biomedical model, health is understood as the result of medical intervention and, therefore, is better left to medical experts to determine. In addition, in public policy, health issues tend always to be compromised by economic issues. Without a strong collective consciousness that gives health a priority, health will never be placed high on the political agenda. It is therefore crucial to make health and well-being a shared vision among the public. The enactment of a new health legislature had to go together with the

forging of new collective health consciousness. The drafting of the National Health Act was aimed as a learning process in which civil society would come together to rethink what health is and how it should be achieved. The new consciousness cannot be confined to the domain of jurisdiction, but must also become the spirit of civil society, a spirit that would inform various civic activities outside the domain of official authority. This second objective of the reform movement therefore aimed at a transformative change in the realm of civic consciousness.

❑ Working Strategies: The Triangle that Moves the Mountain

To achieve the two strategic objectives, a set of working strategies was formulated. Building on prior experience of forging the national movement for political reform which resulted in the promulgation of the new constitution, Professor Dr. Prawase Wasi, an architect of social reform, devised the strategic triangulation of knowledge creation, social mobilization, and political engagement (see diagram). This was known as the "Triangle that Moves the Mountain," a three-pronged set strategies to bring about changes in difficult social issues.



The first strategic mission was to review existing knowledge on various aspects of health and health systems. Knowledge generated through the process would be prepared in ways that were useful for empowering potential actors and enabling collective learning for health systems reform. To enable the broadest participation of stakeholders in the reform process, it was considered critical to create a knowledge base of health reform not only from the conventional biomedical and public health perspectives but also from various other points of view. A broad, multidisciplinary body of knowledge was necessarily for supporting a broad-based social mobilization. Sound and solid technical knowledge of health and health systems was also viewed as a prerequisite for successful engagement with the political establishment to facilitate formal changes in the national health systems through legislation.

In accordance with these working strategies, the NHSRC set up four taskforces to work on each strategy:

1. Technical Taskforce, working on building up a knowledge base and managing relevant knowledge for reform;
2. Civic Mobilization Taskforce, working to engage and encourage participation of civil society in the reform movement;
3. Mass Media and Communication Taskforce, working to ensure that the public was well informed; and
4. Legal Taskforce, working to draft the new health act incorporating the results of deliberation in various civic forums.

The work of these taskforces was expected to culminate in the drafting of the National Health Act, a legislative framework for a new national health system. The aims of the first two years of operation were to build up a knowledge base as well as to create a platform for carrying out reform processes. Critical areas of knowledge that would suggest new ways of conceptualizing health and health system components were

identified. Potential researchers were engaged to prepare groundwork in respective areas. The purpose was to expand the conceptual framework of the health reform initiative in order to create more spaces for various civil society organizations to participate in the reform process. The third year of operation focused more directly on linking the local health agenda identified during the deliberation to national policy processes and on gaining approval for the draft bill in the parliament.

I. Creating Knowledge Base for Reform

Knowledge in this regard was not only confined to biomedical knowledge or public health statistics. Rather, knowledge was defined in a broader sense to enhance collective learning, public deliberation, and the rethinking of health and health systems. Two parallel research programs were set up to review and synthesize relevant knowledge for reform. The first program focused on the institutional arrangements and structural configuration of the health system and its various subsystems. The second program, 'Society and Health Program', aimed at providing broader philosophical and theoretical understanding of health and health care. It was perceived that the conventional notion of health and medicine needed to be expanded so as to invite broader stakeholders and those outside the domain of biomedicine to participate in a more meaningful way in the reform initiative.

II. Social Mobilization and Civil Society Movement

The highlights of the second year of action were the National Health Assembly, which was organized on August 8th-9th, 2002 at the Bangkok International Trade and Exhibition Center, and the nationwide campaign to gather 5 million signatures of supporters for the new national health act. In working towards these two events, a series of civic forums, workshops, conventions, and district/provincial assemblies were organized. In addition, the "Reform Forum," a newsletter aimed at

connecting various movements to the health systems reform, was published by the HSRO. The meetings at various levels as well as the newsletters served to engage the greater public and to build consensus on the desirable health systems among various people.

District forums were organized by various civic groups in collaboration with local health agencies to encourage participation of grassroots organizations. Five hundred and fifty forums took place at the district level during the second year of action. These forums provided a space where local health issues were discussed, information exchanged, and suggestions made to assure that the new health systems would be relevant to the local health agenda. At the next administrative level, all provinces organized forums for provincial residents and civic groups to discuss and voice their opinions as well as to deliberate on the proposed legal framework for the new health systems. The district and provincial forums drew more than 50,000 people from 3,300 organizations around the country. The process of consultation and civic participation created a unique broad-based civil society mobilization. These district and provincial forums culminated in the National Health Assembly on August 8th-9th, 2002, where almost 4,000 participants gathered and expressed their support for the reform.

Public forums have become not only a process of consultation and debate over health problems, but also a process of collective learning among communities, civil society organizations, and health agencies. Civic initiatives and deliberative action in tackling health problems were enthusiastically exchanged between participants in public forums. Through these forums, a new form of public life emerged. People from different organizations who shared similar concerns came to know each other and started building networks of cooperation. In a sense, the forums have become civic infrastructure within which deliberative action and collaboration between civil society organizations became possible.

III. Political Engagement for Legislative Reform

Engaging political institutions in support of the new health systems was considered a crucial mission for the reform process. The organization of the NHSRC itself provided a platform for political engagement. The Committee was chaired by the Prime Minister with Ministers and Permanent Secretaries from various ministries as members. Other working groups, taskforces, workshops, seminars, and civic forums provided platforms for political participation. The first national seminar on "Desirable Health Systems for Thai People" was attended by the Minister of the Prime Minister's Office as well as many leading Senators and Members of Parliament. Since the very beginning of the movement various political leaders and elected representatives were invited to participate in and contribute their ideas on the reform movement in various forums.

The process of drafting the new Health Act began with the development of a legal framework for the new health system using a process of continuing discussion among health experts, legal experts, political leaders, as well as representatives from civil society organizations. By the end of the second year, the draft National Health Act was completed. It provided a working definition, clarification of related concepts, explanation of the rights and duties of the state and citizens, description of various components of the national health system and their functions, and accounts of structural arrangement and working mechanism of desirable health systems. The draft was delivered to the government for consideration and approval in the Cabinet before handing it over to the Parliament.

The following section provides detailed analysis of how the guiding principles, ideas, and strategies of reform were transformed into practice.

Health Systems Reform: From Principles to Practice

I. Creating the Knowledge Base for Health Systems Reform

❑ Creating the Knowledge Base for Health Systems Design

The Technical Taskforce was appointed by the NHSRC at the outset to work on creating a knowledge base for reform. The taskforce was to set up a research program in order to develop a body of knowledge for design of the new architecture of health systems. The taskforce identified fifteen research topics as crucial for rethinking and reinventing health systems. Most topics were concerned with the structures, processes, and subsystems within the comprehensive national health system. The aim of the review was not to determine how the new national health systems must be configured. Rather, the aim was to provide solid technical support for civic deliberation in order to create a well-informed public debate on the new health systems. Topics of the review were classified into five groups as follows:

Policy Processes and Structural Organization of Health Systems

Review of concepts and practices in health systems reform.

Structure, systems and processes for healthy public policies.

Health impact assessment and participatory public policy process.

Medical technology assessment system.

Health security and universal coverage of health care

The roles of public, private, and civic sector in health care.

Structural and organizational arrangement of national healthcare system

Systems for the protection of consumer and patient's rights.
International experience on universal coverage: Lessons from 10 countries.

Health Promotion

Self-care at the individual, household, and community levels.
The roles of mass media, health promotion, and health system development.
School health program and students' health behavior.
National system for health promotion.

Disease surveillance, prevention, and control

Framework for the reform of national disease prevention and control
Surveillance system for disease prevention and control

Health Service System

Primary care system under the universal coverage scheme
Integrating indigenous and alternative medicine into the national health service system
Health manpower development
Health service quality and hospital accreditation system
Emergency medical service system
Financing national health services
Health service for the disabled
Health service for the elderly

Information and knowledge management

Health and medical information system
National health research system
Research and development in pharmaceutical and medical technology

Potential researchers working in relevant areas were identified and commissioned to conduct the reviews. The idea was to review and assess not only concepts and theories in respective areas, but to examine concrete examples of various ideas and approaches. It was expected that the case examples would be particularly useful to encourage and facilitate public dialogue focused on concrete possibilities. The commissioned researchers were also to suggest necessary structural changes and institutional arrangements that would enable the new health system to operate according to the recommendations. Suggestions regarding specific legislative arrangements from relevant international experience were also requested. These requirements were made explicit in the terms of reference and the agreement accepted by each researcher or research team.

The processes of review and research of these topics were organized deliberately for broad participation and for the collective learning experience of concerned parties. Seminars and workshops were organized to identify and refine the essential research questions. Concerned civil society organizations as well as academics and politicians were invited to participate in the continuing dialogue, which led to an acceptable conclusion in each area of research. The research results were produced not as final verdicts of each problem area, but as input for further discussion and deliberation among wider networks of concerned civil society organizations in various civic forums.

The reviews and analyses were also used to produce a technical report, "Principles, Objectives, Mechanisms, and Critical Issues for Health Systems Reform and the Drafting of the National Health Act". This paper was used as a conceptual tool to stimulate discussion and to provide tentative ideas for further elaboration. During the first two years, a number of technical workshops and conferences were organized to scrutinize reports and review results. In addition to workshops and conferences on specific issues, there were also a number of workshops and conferences to consider the overall health

systems as well as discuss how the reform initiative should proceed. These workshops and conferences were:

- Workshop on "Health Systems Reform," December 25-26, 1999.
- Conference on "Partnership on Health Systems Reform," at the Ministry of Public Health, on March 3, 2000.
- Meeting on "Desirable Health Systems for Thai People," May 3, 2000.

The meeting on "Desirable Health Systems for Thai People" was particularly important. It was the first meeting aimed at encouraging public attention to the problems of health systems and raising the issue of health systems reform. More than 200 participants including researchers, health administrators, social and political leaders, and media representatives participated in a discussion on the current health system and desirable characteristics of a new health system. The meeting was chaired by Professor Dr. Prawase Wasi and was broadcast live on national television for the broader public. Using an open format, the meeting helped to bring out voices and concerns regarding various aspects of existing health systems. Most importantly, the meeting created a consensus, a shared vision of the necessity of a new health system and a sense of ownership at the outset of the reform initiative. The event, a watershed for the reform movement, resulted in a book documenting the deliberations. In addition, the video recording of the meeting was edited and used as input for many subsequent meetings.

To ensure broader involvement by the public following the December 1999 meeting, six meetings were organized at the regional level. The regional meetings were intended to develop a stronger understanding of regional needs and demands for health reform. In addition, numerous small meetings and technical workshops were held at the Health Systems Research Institute on topics related to health systems reform. These meetings, workshops, consultations, and

conferences culminated in an August 2000 national conference organized by the Health Systems Research Institute. More than 1,500 participants nationwide attended the national conference on "Civic Deliberation towards the Health of the Nation."

National Conference: Civic Deliberation towards the Health of the Nation

This three-day conference aimed to create a shared idea of health systems reform. Each day was dedicated to one aspect of the "Triangle that Moves the Mountain" strategy. The conference began with the presentation of an analysis of the national health situation and trends as well as the conclusion form the meeting on Desirable Health Systems for Thai People. In the afternoon, twelve civic forums were organized to discuss specific issues focused on geographical regions (north, south, northeast and central regions) as well as specific problem groups (the health of the poor, the elderly, women's health, workers' health, and urban health). Special forums for professional associations and health personnel were also held for community nurses and pharmacists. On the first day, a forum discussing health innovation explored various community and hospital initiatives on medical care and health development.

The second day focused on presenting the results of the research review and relevant knowledge for reform. In addition, some interesting issues emerging from the workshops and regional forums were also included. The objective was to create an interactive learning process between researchers, people, and civic associations from various social sectors. Each forum was organized to encourage discussion and the expression of different viewpoints. The issues presented and discussed included the following topics:

- Mass media and health reform
- Information and communications network for health
- Disease prevention and control

- Self care
- Primary care and family practitioners
- Healthy ways of life and lifestyle
- Indigenous healing and self-reliance
- Reforming emergency medical care
- Healthy public policies
- Health Promotion Fund
- Decentralization and the health system
- Legal measures and health
- Healthy cities: environmental issues and health
- Participatory hospital governance
- Health security and universal health care coverage
- Consumer rights protection
- Community empowerment for health
- New social movement for health
- Grassroots economy, community saving, and health development
- Green marketing and health promotion

The conference was conducted in an open format, inviting people from academia, grassroots communities, non-governmental development agencies, health personnel, and government agencies to deliberate on the researchers' proposals. The final day wrapped up the conference by looking forward and proposing ideas and concepts on how legislative measures, civil society mobilization, and governmental support should be enlisted to strengthen health systems reform.

❑ Expanding the Concept of Health, Broadening the Alliance for Reform

To broaden the knowledge base for further reform movement, attempts were made to expand the operational definition of health. The broadening of the concept of health was meant to widen the scope and

prospect of civil society participation in the health reform movement by moving beyond the biomedical model of health that emphasizes the role and authority of specialized experts and medical high technology. The process of "de-medicalization of health" began with a technical workshop to identify crucial areas of knowledge that would provide a new framework for the broader interpretation of health. Five main areas were identified as important themes for the groundwork preparation:

- History of Thai medicine and health systems
- Philosophy of science and medical paradigms
- Humanizing health care: primary care and health system reform
- Civil society and health development
- Health and human rights

Working groups on each of these areas undertook the groundwork of situational analysis, identifying potential researchers and actors, reviewing the existing body of knowledge, setting up a research agenda, and creating collaborative networks. The detailed ideas and action in each area are as follows.

1. History of Thai Medicine and Health Systems

In order to forge a reform movement that built on lessons learned from the historical evolution of the Thai health system, a program on "History of Thai Medicine and Health Systems" was created and a thematic review was undertaken. A national workshop was organized to assess the existing works in the field as well as to set up a research agenda on further research. Forty participants including medical historians, researchers, archivists, and health system administrators were invited to participate in the August 2001 workshop. Four recently completed studies on the history of medicine in Thailand were presented at the workshop as case illustrations to stimulate discussion. They were:

- "Politics and Socio-Economic Transformation of the Thai Health Care System" by Chanet Wallop Khumthong of Chulalongkorn University,
- "Changes and Evolution of Local Medical Systems in Northern Thailand" by Malee Sitthikriengkrai of Chiang Mai University,
- "The Life and Work of Professor Dr. Sem Pringpruangkaew" by Santisuk Sophonsiri of the Thai Holistic Health Foundation, and
- "Important Reforms of Health Care System in Thai Society between 2431-2543 B.E. (1988- 2000)" by Vichai Chokwiwat of the Ministry of Public Health.

Assessment of the existing knowledge of the history of Thai medical systems suggested that little attention was given to this field. Other than a handful of studies of the evolution of official medical institutions, there has been no attempt to examine systematically various historical dimensions of health systems in Thailand. The workshop suggested that a program on historical studies of Thai health and medical system should include not only history from an official perspective, but also historical experiences of people, local communities, as well as the history of various indigenous systems of healing in Thai society. Attention should also be paid to the social and political consequences of changes in medical systems to better understand the long-term effect of reform processes. It was agreed that not only retrospective studies of the history of Thai medicine and health systems, but also a prospective approach, were crucial. The workshop suggested that an archive on Thai health systems must be set up to systematically compile official documents and records in order to facilitate further research and interest in the field of medical history and the history of health systems in Thailand.

Results from the technical workshop were published as "State of Knowledge in Health and Medical History of Thailand" (see Komatra

& Chatichai eds. 2002). It includes the research agenda as well as a bibliography in the field of medical history. In addition, a proposal to build an archives on Thai health systems was in the process of being approved by the Ministry of Public Health. It is expected that the archives will be built in the fiscal year 2005 and will be able to start operations within the following year. Other than providing systematic access to collected official documents on health, medicine, and health care, the archives will also provide support for research and historical studies as well as other academic activities.

2. Philosophy of Science and Medical Paradigm: Expanding the Operational Definition of Health

The prevailing definition of health was based on a biomedical model of health, which stressed biological factors as the determinants of health. Such a model was strongly influenced by the reductionistic and dualistic paradigm of physical science. The psychosocial and humanistic dimensions of well-being were downplayed. Such a narrowly perceived definition of health led to a restricted approach in achieving well-being, often relying on high technology and costly biomedical interventions to solve health problems. At the same time, it limits the roles in which non-medical actors and communities could participate in health policies and actions.

In order to expand the knowledge base for broader participation, eight areas of research were identified as crucial for a shift toward a new paradigm of health that takes into account biological, psychosocial, and spiritual dimensions of well-being. It was expected that a new concept of health, expanded to include multiple dimensions of well-being, could facilitate further cross-border collaboration. The eight areas include:

- Death and dying
- Health and humanity
- Alternative / complementary medicine

- Alternative paradigms in local health cultures
- Holistic paradigm in family medical practice
- Health in an ecological perspective
- Spiritual and aesthetic dimensions of health
- Health and learning experience

The justification and criteria of selecting each topic was based not only on the significance it has for the concept of the new health system, but also the possibilities for creating a broader alliance for the health system reform movement. During the first two years, potential researchers in each area were identified. An August 2001 technical workshop developed strategic plans in each area. The workshop comprised fifty participants including palliative care clinicians, philosophers, social scientists, health and medical professionals, journalists, health system researchers, educators, NGO workers, and artists. Short paper presentations and technical discussions preceded the formulation of a strategic plan of action for each area. Groundwork in each area was undertaken and the outputs were presented in various forums. The proceedings from the August 2001 workshop on new health paradigms were published and widely distributed (Komatra, Nongluk, and Pot, eds 2002). The eight working groups in each area served as focal points for the networking of researchers and research institutions interested in each area.

The following are brief descriptions of the significance of and activities undertaken in each area of research.

Death and Dying

Estimates show that more than 70 per cent of the health and medical expenditure in the United States was used for intensive or high tech, critical medical care during the last six months of life. The fact that modern medical institutions contained little knowledge with regard to dimensions of death and dying other than the biological aspects was due to its paradigmatic assumptions. The dominant medical paradigm

puts great emphasis on extending life to the extent that death and dying became a taboo subject among the health profession: the arch enemy of medicine. Popular perception on death and medical intervention has been diverse. Some argued that the medical war against death and dying was in fact a zero-sum game. Others went further to stress that struggling against death and dying could create unnecessary suffering and impose high costs. Understanding death and dying was therefore crucial and had important implications for the health reform movement. To better understand the problem, a review project was undertaken to examine the following issues:

- Situation of death and dying among various socio-economic groups in society
- Local knowledge and cultural practices on death and dying
- Legal approaches to death and dying including euthanasia, and
- Knowledge and skills needed by health professionals working with terminal patients and their families.

The result of the review formed the groundwork for the formulation of a comprehensive program on "Dying in Peace and Spiritual Health," to be supported by the National Health Promotion Fund.

During the drafting of the National Health Act, the right to die peacefully and to die with dignity became a heated debate. The situation as well as knowledge on existing experience in approaching the issue turned out to be crucial for informed debate. Although a consensus was not reached on the issue, it was a healthy debate embracing various viewpoints ranging from legal to religious orientations. The debate was recorded and published as a book entitled "The Right to Die Peacefully with Dignity." The issue of peaceful death and dying with dignity is an important subject, requiring a continuing dialogue before specific consensus can be reached.

Health, Disease, and Humanity

Disease and illness have ramifications far beyond individual physical bodies. Xenophobia, stigmatization, accusations and other forms of dehumanization of patients are well known. The understanding of the interactive processes between health, medicine, and humanity is crucial to the prevention and rehabilitation of unnecessary adverse consequences of disease and illness. A review of the situation and existing body of knowledge was needed in order to develop a framework for further actions. Such an understanding would bring together health and humanistic dimensions in the health reform movement.

A review project was undertaken by the Center for AIDS Rights, using the problem of AIDS and people living with HIV/AIDS as an example of how dehumanization takes place. The result provided a framework for the drafting of the new health system act. It also provided groundwork for further development of practical guidelines for health professionals and non-governmental organization workers.

Alternative and Complementary Medicine

Medical pluralism has been an important characteristic of most health systems in the world. Over the past few decades, alternative health and complementary medicine have become increasingly popular in Thai society. More than 200 organizations including self-help groups, alternative health advocates, non-profit organizations, and modern medical hospitals have become involved in the promotion and application of alternative medicine in patient care. Alternative medicine differs from allopathic medicine not only in the methods of restoring and maintaining health, but also in the conceptual and organizational aspects of how health is perceived and how caring systems are organized. Models for the integration of appropriate alternative medicine require an understanding of the differences between various explanatory models of health and illnesses in different systems of healing.

Epistemological differences between various medical paradigms of alternative medicines were an important aspect emphasized in the review. As the process of reform unfolded, indigenous healers and practitioners of alternative medicine became increasingly active in finding a role in the official national health system. Understanding the review process contributed importantly to the debate and the drafting of the new national health bill in order to integrate traditional and alternative healing into the national health systems.

Health Paradigms in Local Health Cultures

Local cultures affect health through cultural practices and cultural contexts within which human interaction and behavior take place. Local cultures provide structures of meaning that serve as frameworks for the interpretation of illness experiences. Local health cultures also provide communities with health resources such as healers, knowledge on herbal uses, and health maintaining and restoring techniques. Indigenous health concepts and medical practices often have different cosmological and epistemological assumptions. While modern medicine adheres to a bio-mechanistic worldview, indigenous systems of healing view the world as animated by humoral elements or supernatural powers. An understanding of local cultures and indigenous systems of knowledge existing in Thai society would help adapt health systems and make them relevant to local cultural contexts.

As the reform initiative also strongly emphasized self-care, understanding local health cultures and social behavior related to health became crucial. The task of bridging differences between biomedicine and indigenous understanding of health and healing was easier said than done. The difficulty was not in reconciling differing methods of disease treatment; rather it was the huge differences between the distinctive ontological and epistemological assumptions of reality that needed to be bridged. The review revealed the underpinning principles of local health

cultures and proposed a continual dialogue across disciplines to facilitate cross-cultural understanding.

Holistic Paradigm in Family Medicine

There has been a recent surge in interest in family practice in Thailand, particularly after the implementation of the universal health care coverage scheme. This was partly due to the attempt to strengthen networks of primary care providers that would provide holistic and integrated care at the community level. The creation of family practice and primary care units, however, seemed to pay more attention to form and quantity rather than content and the quality of care. Nonetheless, there were a number of interesting cases of community hospitals that took holistic care seriously and became active in developing practice models for primary care service and family practice. Local sub-district administrations have displayed clear interest in investing in this new development. Examples range from community outreach programs in Khorat and other provinces to local governments starting scholarship for local students to go to nursing school in order to come back to work as community nurses. An exploration and review of these examples was conducted to examine how holistic care can be promoted, particularly with the support of local sub-district administrations.

Health in Ecological Perspectives

New ecological movements, such as deep ecology and eco-feminism, construe health as an integral part of ecological and spiritual well-being. There has been an increase in Thailand, not only in ecological awareness, but also in the number of organizations working in environmental and ecological issues. Linking health with ecological concerns has become critical not only because of the increase in environment threats to health, but also as a way to connect health reform to active environmental movement. The groundwork in this area sought to assess the current situation and to develop a framework and

common language to connect health reform and the ecological movement. A group of researchers and activists was formed to review the situation and build up technical understanding and a relevant framework to facilitate future work in this area.

The review aimed to provide groundwork on ecological perspectives of health. The result of the review not only included theoretical understanding of the field, but also provided case examples of how health was alternately perceived and realized through organic agricultural practices and alternative natural resource management. Active individuals and organizations in the field were also listed, providing a resource both for the reform process and for networking of people in this field.

Health, Spirituality, and Aesthetics

In the dominant paradigm of biomedicine, health is defined and conceived as a state of normal bodily functions and biological processes. Mind and body are viewed as separate entities. In the world of biomedical reality, therefore, the multiple dimensionality of life has been reduced to its material or bio-physiological dimension. The epistemological assumptions of modern science preclude inquiry into the realm of existential experiences because they cannot be objectively examined. Studies in new scientific paradigms seem to offer a new path of investigation for the purpose of redefining health. The holistic paradigm proposes that in a complex system the whole is always more than the sum of its parts. Spirituality and humanity are among the emergent properties in the complex organism of the human, recognized as important aspects of well-being. Such characteristics of the whole cannot be reduced or understood by the properties of its elements.

Spirituality is not necessarily religious or otherworldly. Spiritual fulfillment can also be rooted in a secular world and non-religious ideology. The efforts of feminist activists, people working in ecological conservation groups, anti-nuclear movement,

charitable organizations, or development agencies to fulfill their vision of a good life can also be considered as spiritual quests. The close connections between health and spiritual life are hardly acknowledged in modern medical science. A framework to assess and build the idea of the importance of spirituality to health and well-being would help to facilitate the collaboration of various religious traditions in seeking a more humanistic way of addressing human illness and suffering.

The review resulted in a report addressing various epistemologies and the shift toward a more holistic approach in life science. Although the importance of the spiritual dimensions of health were well accepted by various parties in the health systems reform movement, some consensus and reconciliation was still needed among differing religious orientations, particularly on terminology used in official documents. However, the review was useful in situating various viewpoints on spirituality and health into a broader theoretical perspective. It was therefore possible to conceive a continuing dialogue between differing knowledge traditions for further understanding and development in the field of spiritual health.

Health and Learning Experience

Health education and professional education of health and medical personnel have been based on a didactic model of learning. Lessons learned from various self-help groups, particularly people living with AIDS and cancer survivor groups, suggest a critical distinction between "education" and "learning." In health and medical education, emphasis has been given to "teaching" and "educating" in which professional authority and experts possess and impart the correct answers to health and medical problems.

The new pedagogy and alternative educational models emphasize a horizontal approach to learning processes in which various parties engage in continual dialogue to realize their own potential. Knowledge on existing educational practices and how to apply a new pedagogi-

cal approach in forging a new learning society in health is of critical importance. A working group was created to undertake a situational review examining concepts and identifying key actors in this field. The review results were particularly useful for the debate on how to define spiritual health as well as how to apply the concept to specific health policies or programs, such as a spiritual health impact assessment of the developmental project.

3. Humanizing Health Care: Primary Care and Health Systems Reform

Although one of the most important elements in Thai health system reform is the creation of a universal health care coverage scheme, implementation requires a strong network of primary care providers. As mentioned earlier in the historical review, the evolution of the Thai national health systems has been strongly dominated by the biomedical model, emphasizing high technology and specialized medical care. Under such circumstances, creating a primary care system required understanding and support from a wide range of health professionals. The objectives of this program therefore aimed to:

1. Build a vision of primary care among various health professionals, and
2. Sharpen working tools to strengthen the holistic approach in primary care.

The new vision of primary care required a new structural arrangement within the existing system, forged through interactive learning among various stakeholders. Otherwise, changes in the structure of health care organization would invite strong resistance from the existing professional organizations. In current use, the concept defines primary care-givers as merely "gatekeepers" and relies on reform of financing mechanisms to enforce structural change in support of primary care. So far, such an approach has had unfavorable results,

including patient's dissatisfaction and deteriorating self-esteem among primary care providers. This project proposed to interpret primary care with a greater emphasis on community health, stressing cultural and human dimensions of health and caring. To realize this vision of humanistic primary care, tools to strengthen the holistic approach were therefore critical. The following activities were implemented during the first two years of the reform.

1. A review of current knowledge and existing operational models in primary care. Emphasis was given to community components in primary care service. Various approaches to community work, not only in health development, but also in other domains of community development work were reviewed and evaluated.
2. The preparation and production of a community action field book. Anthropological concepts and tools were adapted and applied to help local health workers better understand cultural components (such as belief system, kinship structure, social organizations, and local indigenous healing system) of health and illness. Understanding of human dimensions was also emphasizd through collecting illness narratives and life stories. In February 2001, the first draft of the handbook was completed. To introduce the handbook to health administrators and primary care workers, a launching seminar was organized on February 19, 2001 with more than 700 participants. Seven hundred copies of the field book were distributed for testing and evaluation.
3. A number of workshops were organized to refine the tools and their applications as well as workshops for training trainers to promote the use of the tools. By the end of the second year, more than thirty training workshops in twenty provinces were organized.

The field book was later published as *Community Approach: a Field Book on Anthropological Tools for Community* Work in Primary Care, a 200-page handbook on how to apply anthropological tools to community health work. The book provides a clear scope of primary care and its relations to institutional care. and has been generally used to train primary care providers in social and cultural dimensions of health and to strengthen their ability to provide holistic care.

4. Civil Society and Health Development

The main focus of this research area was to document the ways civil society was involved in the national health systems reform process. The aim was to generate knowledge on the roles and potentials of civil society in health systems reform and health governance. The following activities were undertaken to document and analyze how civil society was engaged and the ways in which civil society organizations participated in re-imaging and rebuilding health systems at various levels.

(1) Review of situation and relevant literature

Systematic reviews were undertaken of the situation and existing literature on the relationship between civil society on the one hand and health and social changes on the other hand. Six topics were selected for systematic review:

- Current Thai politics and national health systems reform
- "Social capital" and its interpretation in the health reform movement
- Health and participatory democracy: A profile of the HSRO
- Concept and practices in traditional Thai social life
- Public space and civic practices in everyday life
- Tools and methods in the strengthening of civic tradition in Thailand

A group of researchers was formed to undertake the review. They then presented the resulting conceptual framework in a series of small informal workshops organized among concerned academicians and civil society.

(2) Engaging research institutions and researchers

To invite broader participation of senior researchers and academics from higher education institutions in the research process, potential contributors were identified and commissioned to write research papers on various issues related to the development of civil society from global, regional, and national perspectives. The contributions of senior researchers included the following topics.

1. 'Representative Democracy vs. Participatory Democracy: The Future of Democratic Governance,' by Chaiwat Thiraphan.
2. 'Transnational Civil Society Networks and the New Social Movements,' by Amara Pongsapich.
3. 'Globalization, Globalism and Its Impacts on Civic Politics,' by Surichai Wan'keo.
4. 'Civil Society and Health Sector Reform: A Review of International Experiences,' by Komatra Chuengsatiansup.

The understanding generated from these commissioned research papers was helpful in situating civil society mobilization and the health reform movement in the broader theoretical perspective. The reviews and research papers were distributed in various technical seminars, and among researchers and people from civil society organizations. Most of the reports were published and made available (in Thai). They were important inputs for the national seminar on civil society and the health reform movement, which was organized by the HSRO in September 2004.

(3) Development of research network

Four regional research networks were established with the collaboration of regional research institutes. A common research framework was employed to gather relevant information during the provincial and district forums. Researchers from the Faculty of Nursing, Chiang Mai University, the Research and Development Institute, Khon Kaen University, the Faculty of Pharmacy, Songkhla Nakarin University, and the Local Development Institute conducted research on the process of forming provincial forums in the north, the northeast, the south, and the central region respectively. In order to collect information on district forums, 80 researchers were recruited and a one-day workshop was organized to train local researchers on the research framework and data collection. Data collected both from the provincial and district forums were gathered and analyzed to assess the strengths and weaknesses of civil society organizations and civic practices in Thailand.

(4) Creating Database of Civil Society Organizations

Using data collected from provincial and district forums, a database on civil society organizations was created. During the first year of reform, twelve networks of civil society organizations in 69 provinces were identified. In addition to these area-based organizations, there were 14 issue-based networks of grassroots organizations already engaged in the reform process. To better understand the situation of civil society organizations and their potential roles in health reform, four regional seminars were organized in Chiang Mai, Roi-et, Nakhon Sithammarat, and Khon Kaen. Researchers from local research institutions and representatives from grassroots organizations participated in these workshops. These seminars further identified a research agenda and potential researchers to assess the performance and capacity of civil society organizations in each region.

During the three years of the interactive reform process, information on civil society organizations as well as their potential was regularly updated. By the end of the third year, similar regional seminars were organized to reassess the situation. Researchers and representatives of civil society active in the reform process were invited to reflect on their experiences. Based on the information gathered, twenty case studies of civil society involvement in health systems reform were identified and systematically investigated.

(5) Case studies

To document the wide variety of civil society organizations engaging in the health systems reform movement, twenty cases of civic engagement were identified. Detailed investigations of these twenty case studies were undertaken. As mentioned earlier, a number of civic groups and organizations have engaged in the process of health systems reform. Learning from the experiences of these groups and organizations was crucial in understanding how the process of reform unfolded and how consensus was reached or conflict settled. Twenty case studies were systematically investigated using a common framework and standard data collection method. The twenty case studies included six area-based cases, in all regions of the country, and cases relating to the health of the poor, women's health, the role of community radio in the health movement, the role of NGOs in health reform, the indigenous medicine network, the network of physically challenged peoples, consumer protection and community governance, youth and health, the network of community health workers, the Community Nurses Association, community forestry conservation, and organic farming and alternative agriculture movement.

5. Health and Human Rights: Creating a Framework for Reform

Although violations of human rights often damage the health and well-being of individuals and society, little systematic understanding of the interrelation was available. This program set out to explore the relationship between health and human rights in order to build a workable conceptual framework to integrate human rights and health system reform. The ultimate goal of this initiative was to place the right to good health and good health care on the national human rights agenda. During the first year of the program, four areas of work were identified as initial steps for preparing the groundwork:

Situational Analysis of Health and Human Rights in Thailand

A group of researchers and social activists was formed to review the situation and current knowledge on health and human rights in Thailand. In addition to a documentary review, field research was also undertaken to examine local situations as well as local perspectives on the issue of health and human rights. Topics of inquiry included concepts and theoretical relations between health and human rights, comparative analysis of western and local perspectives on human rights, and violations of human rights associated with medical discourse and practice. It was expected that the review would help to establish a national health act based on a solid theoretical understanding of human rights.

Health Reform and Health of the Poor

Health of the poor has not fully been appreciated as a human rights issue. The Forum for the Health of the Poor Project was created to guarantee that the voices of the poor would be heard during the process of health reform. Four regional meetings were organized with grassroots organizations working with the poor, as well as people

from poverty-stricken urban and rural communities. During the meetings, health issues from the perspective of the poor were raised. Four issues of critical significance were identified and investigated. They included: (1) Food systems and food security among the poor; (2) Economic and financial aspects of health from the perspective of the poor; (3) Health security among the urban poor; and (4) Public policies and their impact on the health of the poor. The result of the review was used as input for the process of drafting the National Health Act.

AIDS as Basic Human Rights Issue

To advocate human rights in health arena it is crucial not only to voice the concerns, but also to make available tools and methods for health professionals and development workers to use in their daily practice. A group of AIDS rights activists was formed to review how systems worked to protect basic human rights in medical practice. Case studies were developed to document the experience of human rights violations. Practical ways and means of addressing such violations was drawn upon to write a handbook on health and human rights for health personnel and development workers.

Creating the knowledge base for health systems reform in the preceeding five major areas was undertaken during the first two years. By the end of the second year, the Health Systems Research Institute organized the National Conference on Social Health to disseminate and discuss findings and proposals from the review.

❑ National Conference on Social Health: Founding Public Space for Rethinking the Health System

In the following year of 2002, studies previously undertaken were mobilized to stimulate discussion and stir up new ideas among concerned parties. The August 2002 Centennial Conference of the Health Systems Research Institute served as the focal point for collective learning and rethinking of the definition and concepts of health. The theme

for the conference was "Creating Social Health towards a Peaceful Society." This theme proposed to define health from a social rather than individual perspective (see below). Throughout the conference, the theme "social health" was echoed in various discussions to bring home the idea that health as a collective well-being creates a just and peaceful society.

National Conference on Creating Social Health towards a Peaceful Society August 5-7, 2002, Bangkok, Thailand

The aim of the conference was to create a collective learning process and broaden the concept of health. The theme of the conference was "Creating Social Health towards a Peaceful Society."

The Main Concept

Health is socially determined. People living in a good society get sick less often and when inevitably do so, healing is more obtainable. A conscientious society poses fewer health threats and, through collective effort, restoring ill health is less of a burden for the individual. It is well established knowledge that, in an exploitative society, health of the people deteriorates, families and communities flounder, and the environment depreciates resulting in deprivation, violence, and suffering. Health or well-being of people, be it physical, mental, social, or spiritual, is therefore, a direct outcome of a society; good health comes from a good society, that is a society which is equitable, reciprocal, respectful of humanity, and peaceful. Achieving health of a society is therefore impossible without realizing that health, in the final analysis, is collective.

In a society as wealthy as the United States of America, the center of the world economy, for instance, epidemiological data reveal clearly that diseases are socio-economically distributed. Infectious diseases such as AIDS and tuberculosis, or chronic non-communicable

diseases such as malignancy, hypertension, and diabetes are far more prevalent and devastating among marginalized groups and those belonging to the lower social class. African and Spanish Americans in particular suffer most severely from these epidemics. In societies around the world, preventable and curable diseases, be it AIDS, tuberculosis, malnutrition, pneumonia, hypertension, or diabetes, are still prevalent among the poor, minorities, women, and those who have little power. Diseases and health problems therefore resemble social suffering; they are not accidental occurrences and not evenly distributed among social classes in society. Diseases are socially created and are distributed along the fault lines of society. While disease, ill health, and suffering are concentrated at the margins among the poor and the disfranchised, health and medical resources are mostly concentrated at the center among the rich and the advantaged. Creating health and creating a just society are therefore integrally linked.

However, the root causes of social suffering run deeper than most of us realize. The creation of a good society needs more than equal distribution of resources. Resources will never be sufficient for the needs and greed of a few men or a few nations. Human societies need a whole new way of thought for the collective liberation of social suffering: a way that emphasizes oneness among people and societies before and beyond the crude instinct of exclusivity and individual survival. This new vision has not only to be convincing in rational terms, it has to be spiritually inspiring and motivating to mobilize all sectors in the society into the great learning process. A paradigmatic change from competition and conquest to compassion and community needs a reinvention in the arts and sciences of living together, a reinvention for the transformative appreciation of common humanity and the beauty of simple human relations. A society is a complex whole with multiple dimensions and multiple domains all interconnected. Transformative changes in a system as complex as a human society can never take place simply through the power of the state, as imposed changes and coercive structure will end up creating a new monstrous regime in place

of the existing regime. Most crucial is a revolutionary learning experience for all sectors and all societies to embrace a new collective consciousness that connects all people and all societies as one.

The Thai health system has been incarcerated by a dualistic and reductionistic view, which conceives health problems as merely a biological malfunctioning of individual bodies. Although such a view is sufficient in solving certain physical diseases for a few, it is hardly adequate for the creation of health and well-being for all. Health is not only socially determined, it is collective. When humanity is viewed as an integrated whole, health for a few is hardly health at all. In this collective sense, health is thus the direct outcome of the state of a society. A global society where superpowers dominate and mercilessly take advantage of even the poorest countries under the name of free trade, a society where consumerism is worshipped and materialism eclipses spirituality and humanity, a society where modernity is glorified over local identity and cultural dignity, a society where a culture of terror is the norm and violence is the sole mean of conflict resolution, a society where life is discounted, a society where families depreciate and communities disintegrate, in such societies where collective well-being is impossible, health is never to be achieved. Health and humanity have to be conceived as one, if the collective well-being of humankind is to be realized.

Health and human well-being are not to be achieved through reductionistic intervention. Rather, health as a collective state of well-being is achievable only through a collective effort in which society as a whole — from individual persons, families, communities, as well as various local, national, and global social institutions — engages in the transformation processes. All sectors and all levels of the society need critical learning experience for the collective growth of new consciousness and compassion. This transformation is a Herculean task far too great to be left exclusively in the hands of any single mechanism or methodology. It can only be brought about by the processes of interactive learning through action in which all parties and stakeholders

are invited to participate, to realize their potential, and to appreciate their contributions. Fundamental changes are required not only in the structural dimension, but also in the spiritual and mental dimensions.

The August 2002 conference provided an opportunity for those engaged in health and humanity to come together to renew their commitment, to inspire and to be inspired, to learn and to collectively reflect on issues that concern us all so deeply. The conference organized under the main theme of "Creating Social Health towards a Peaceful Society" marked the beginning of the second decade of the Health Systems Research Institute, a new decade dedicated to realizing collective well-being for common humanity.

Among more than 2,000 participants were government health officers, health administrators, researchers and academicians, non-governmental organization staff, and grassroots community organizations. At the conference, various technical issues were discussed to explore a new interpretation of health, consistent with the collective vision of health outlined above. The conference was organized in three different formats: plenary sessions during the opening and the closing events; technical seminars on specific issues; and a training workshop on tools and methodologies for health reform. Each session addressed the importance of social dimensions of health and proposed alternative views of health and medicine. Some of the issues presented and discussed at the conference were:

Plenary sessions:

- Peace and Health
- Global Capitalism vs. Global Community
- Creating Social Health towards a Peaceful Society
- Society and Collective Well-being

Technical seminars:

- History of Thai Medicine and Health Systems
- Death and Dying: Health Dimensions from Spiritual and Religious Perspectives
- Primary Care and the Humanization of Medicine
- Health and the New Medical Paradigm
- Energy, Health, and People's Power: Energy Policies for People's Health
- Consumer Choice in the Health Market
- Indigenous Wisdom: Folk Medicine and Social Health
- Family Health: Back to the Foundations
- Health in the Workplace: Living and Working in Harmony
- Food System and Food Security
- Creating Peace and Social Health: Stop Violence against Women
- Globalization and Its Impacts on Local Communities
- Healthy Communities and Local Empowerment
- Universal Coverage and Social Equity
- Waste Management: Role of People and Community Participation
- Agriculture and Spirituality: New Linkage of Food Production and Health
- City, Travel, and Health
- Health Dimension in Small and Medium Sized Enterprises

Training workshops:

- A Workshop on Living and Dying Peacefully
- Health and New Ecological Consciousness: A Meditation Workshop
- Health Public Policies: Health Impact Assessment as a Tool for Healthy Society

- Health and Peace: A Training Workshop on Non-violent Conflict Resolution
- Child Development: Training on Tools and Method
- Training for Trainers on Anthropological Tool for Community Primary Care
- Long-term Research Capability Strengthening

The main outcome of the conference was an awareness of a new health concept, a concept of social health that fosters a different idea of health from the disease-oriented and individualized health of the conventional medical worldview.

The conference was immediately followed by a national assembly to discuss the legal framework of the new health system. The assembly was organized in an informal atmosphere to enable people from all social groups to participate. Local health initiatives were put on display as part of the exhibition to show how local communities could be encouraged to take charge of their own health. Representatives from civil society organizations participated in discussing and suggesting ways to improve the proposed legal framework. Legal experts, health experts, and people from grassroots community organizations exchanged ideas, aided by a well-prepared group of facilitators. The Prime Minister attended the closing ceremony, and received the resolution of the assembly, with a pledge to support the promulgation of the new national health bill as a means to create a solid foundation for new health systems in Thailand.

II. Social Mobilization and the Civil Society Movement

❑ Engaging Civil Society: The Operation of Reform Strategies

With the review of concepts and practices on creating a knowledge base for reform as the background, this section of the report examines in detail the operation of working strategies in mobilizing civil society in the reform process. The process of civic engagement and the increasing roles of civil society in the domain of health policy and action must be understood within the larger political contexts and the continuing transformation of health systems discussed earlier. The strategy and experience of the social mobilization and civil society movement discussed in this section will reveal how civic engagement strengthened the deliberative function in health governance.

❑ Health Systems Reform Office, Civic Mobilization, and the Deliberation of Health Systems Reform

In building a broad-based social movement for health system reform, with the HSRO as the coordinating body, three strategic missions were identified as critical for forging a successful health reform movement. The first mission of creating a workable body of knowledge to enable a knowledge-based reform has already been discussed in the preceding chapter. The second and third strategies were: (1) Social mobilization and civil society involvement in the reform initiatives, and (2) Engaging political machinery to ensure structural changes through legislation. This section will examine the process of mobilizing civil society and civic engagement that aimed to foster public involvement in health system reform. Of particular importance are the ways the working relationship between civic groups and the HSRO as a coordinating mechanism were developed and sustained.

As will be evident by the end of the analysis, civic participation was mobilized by creating a new social space, a venue within which various elements of civil society could deliberate on how health should be understood, the desirable health systems, the objects of reform, and how reform processes should be carried out. Such deliberation of health system reform was possible only through the cultivation of a healthy working relationship, a relationship that respected diversity, valued inclusiveness, and tolerated differences.

❑ Public Forums and the People's Health Assembly

The constitution of 1997 has become a symbolic representation of new politics in Thailand, marking a further evolution of representational democracy in the Thai political system. In the spirit of the new political consciousness, the process of designing the new health system was carried out to ensure the broadest possible range of participation. As the preceding chapter indicates, the existing system of health governance emphasized top-down implementation of a predetermined program of health development. The approach precluded meaningful public participation in the processes of policy decision-making or program design. In other words, community participation occurred during implementation and not deliberation. The civic deliberation of health systems reform was carried out as a counterpoint to the existing bureaucratic model.

In an attempt to move towards a more inclusive mode of deliberative democracy, it was realized that mechanisms and processes that would create spaces in which the public could participate were needed. A range of public forums at various levels were therefore created.

As mentioned earlier, at the very beginning of the reform process, a brainstorming session was organized, focused on "Desirable Health Systems for Thai People," with partipants from all parts of society including the religious sector, labor organizations, professional

associations, political society, business sector, alternative health advocates, community organizations, mass media, human rights advocates, and academics. The meeting was chaired by Professor Dr. Prawase Wasi and was broadcast live on national television. The result of the brainstorming was later published and distributed for further debate.

After this first meeting, six regional meetings were organized in order to broaden the participation at the regional level. Regional meetings were the result of collaboration between the HSRO and local civil society organizations co-hosting the events.

1. In the upper northern region, the meeting was organized in Chiang Mai Province with approximately 200 participants from various governmental and non-governmental organizations. The topic was "Giving Back Health Knowledge to the People." The meeting was chaired by a well-known local activist and was co-organized by a group of local radio broadcasters who broadcast the meeting to local communities.
2. The lower northern region meeting was organized on August 3rd, 2000 in Phitsanulok Province. The meeting was entitled: "Reforming Health System: Step One, Reforming the Way of Thought." Almost 500 participants from eight provinces participated in the meeting. Local organizers were the Foundation for Phitsanulok against AIDS and the Indo-China Crossroad Institute.
3. The upper northeastern meeting was organized in Khonkaen Province with 224 participants from eleven provinces. The meeting topic was "Way of Life, Way of Health for Northeasterners." Organizers of the meeting were Khon Kaen Hospital and the Udon Provincial Health Office. The meeting was broadcast live on a regional radio station that covered all major provinces in upper northeastern region.

4. The lower northeastern meeting was held in Nakhon Ratchasima Province at Sima Thani Hotel. The title of the meeting was "Decentralization and Local Administrative Agencies." 442 participants from eight provinces participated in the meeting. The event was organized by the provincial health administrative office.
5. In the upper south, a meeting, entitled "From Health Consciousness to Maintaining equilibrium of Life," was organized in collaboration with Walailuk University and the Network of Southern Civil Society. 155 participants from seven provinces participated in the meeting. The meeting was broadcast on national television covering all the southern provinces.
6. The sixth meeting was organized for the southernmost provinces. It was organized in collaboration with a local civic association and the network of 45 civil society organizations in Narathiwat Province. More than 300 participants gathered to discuss the issue of "Spirituality the Religious Value: The Driving Force for Health Systems Reform."

These regional meetings started a continuing dialogue between the HSRO and civil society organizations nationwide. At each of the meetings, respected public figures as well as local leaders played crucial roles in stimulating local members of the public to voice their opinions. The ideas and expectations during the three years of the reform movement were also discussed. In the following years, thousands of community and provincial meetings were organized to stimulate the public to rethink health systems.

❑ The First Year of Civic Engagement: Creating Forums, Inventing Public Space to Rethink Health System

In the following year, more than 500 forums were organized at various levels of society. A booklet proposing an initial conceptual framework for the reform was published in February 2001 and used to initiate debate and discussion. It was also used as an educational tool to launch learning processes in various civic forums. Most of these forums were held among civil society organizations in collaboration with local health authorities. In August 2001, six additional sub-regional forums were organized in the provinces of Phitsanulok, Ratchaburi, Khon Kaen, Surat Thani, Songkhla, and Surin. By the end of the year, more than 40,000 participants attended the forums to learn and deliberate on their health problems and solutions. In addition, the "Reform Forum," a newsletter aimed at connecting local movements and sharing ideas on health systems reform was published. The meetings at various levels as well as the newsletters served to engage larger public involvement and to build consensus on a desirable national health systems among various sectors in society.

The first year of civic engagement ended with a gathering of civil society organizations to exchange their ideas and experiences at the "Health Reform Bazaar." Technical sessions were organized for health experts to discuss and share their views on health system reform with local civic associations. These technical sessions were held parallel to the National Health Assembly, where delegates from civil society organizations put forth their views and opinions on the agenda of health systems reform. Not only was this first civil society assembly intended as an experiment to demonstrate how health policies could be deliberated in civic forum, but also the views expressed were recorded and summarized. The result was used as the basis for developing a legal framework for the National Health Act, which was published and widely distributed by the end of the first year.

❑ The Second Year of Civic Engagement: Civic Deliberation and the Creation of Legal Framework

The second year focused on generating more debate on the legal framework of the reform. Based on the proposed outline of the new legislation, additional civic forums were organized with an emphasis on district and provincial levels. The aim was to discuss the relevance of the framework for practical issues faced by local communities and groups. This second year was kicked off by five regional forums organized to deliberate specifically on "national health policy processes," which was an important element to be included in the drafting of the National Health Bill. Debated in the regional forums were issues such as the composition of the National Health Committee, the process of selecting representatives from civic communities, and the design and functions of national health mechanisms. It was also suggested that a national health assembly should be organized annually and health assemblies on specific problems should be held whenever necessary. These suggestions were collected and used to revise the working framework for the National Health Act.

When the first draft of the National Health Act was on the way, a series of training workshops were arranged for district facilitators who would help to organize district meetings to deliberate on the draft bill. Four regional training workshops were held in the north, northeast, south, and central region including the eastern and western regions. There were a total of 263 participants from all 76 provinces. Participants in the workshop were informed of the concepts and design of the bill, how the structure of the draft bill was developed, and how each component of the bill was drawn up, as well as how to organize district meetings so as to encourage participation in deliberation on the bill. Five issues were initially proposed as possible examples for more extensive debate in district meetings, namely, the health policy process, factors threatening health and healthy public policies, consumer protection, primary care system, and the roles of local indigenous

healing practices. These were only suggestive issues to be discussed. The agenda for each district meeting, however, was determined by local participants.

❑ District Forums and the Deliberation of Health System Reform

By the end of the following six months, 526 district forums were organized with a total of 27,222 participants. District meetings encouraged local people to rethink and reclaim their active roles in determining the characteristics of the national health system. The process of deliberation was an active learning process in which people came to understand themselves as active citizens and not just passive subjects of the state. This civic education was evident in how the process brought about deep contemplation and collective reflection on issues such as the values of local indigenous healings or the social origins of diseases, and the needs of healthy public policies.

In addition, forums were also organized on specific topics of concern such as women's health, health of the disabled, contract farming and agricultural use of pesticides, social and health impact assessment, and health of the poor. These forums culminated into the National Health Assembly 2002, with the main focus on deliberations of the draft National Health Bill. Workshops and forums were arranged on specific issues raised during the district and provincial forums. The closing ceremony of the National Health Assembly 2002 was presided over by Prime Minister Thaksin Shinawatra who, before a cheering crowd, vowed to process the bill to fulfill the wishes of the assembly.

❑ The Third Year of Civic Engagement: Connecting Local Agenda with National Policy Processes

As the process of drafting the National Health Act was well underway, the third National Health Assembly had less to do with the legislative aspect of reform. Rather, the focus was on creating an alternative space so that local health agendas and initiatives could be

expressed and shared among participants. To prepare for the 2003 assembly, provincial and regional forums were encouraged to select specific issues that were important to the health and well-being of the region. These regional themes were debated at the provincial and regional forums. They were then placed on the agenda of the national assembly in order to connect local health concerns with the national policy processes. Themes derived from regional forums and deliberated at the national health assembly included:

1. Themes from the northern region: agricultural policies and practices and their impacts on health; traditional knowledge and indigenous healing systems.
2. Themes from the northeastern region: healthy public policies; healthy agricultural policies and practices.
3. Themes from the central region: holistic health care; and water resource management and energy policy.
4. Themes from the southern region: religion and women's health; tourism and health impacts.

Conclusions derived from the assembly covered a broad range of issues. The forum on agricultural policies and practices noted that health impacts of agricultural practices were usually related to food safety, and concerned mostly with the safety of the consumers. The forum suggested that the concerns must be expanded to cover farmers' safety, as it was evidently clear that there has been extremely excessive use of chemical fertilizers, pesticides, insecticides, and weed killers in agricultural practices. The forum proposed that a ban should be imposed on the importation of excessive agricultural chemicals.

The forum on holistic health care proposed that the development of a primary care system must be emphasized, and that the pluralistic medical systems, which have long existed in Thai society, must be better harnessed by making them work together in a more integrated and complementary way.

The forum on religion and women's health paid special attention to how a cultural and gender-sensitive health care system could be devised. Participants from the southern region of Thailand, who were mostly Muslim, suggested that more female medical personnel were needed, especially for providing care that was gender specific.

The forum on tourism and its impacts on health argued that sustainable natural resources management and health were two sides of the same coin. Local citizens must have more say on the use of local natural resources. Public hearings as well as social and health impact assessment of policies, plans, and implementation of tourism promotion must be established as a means for participatory healthy public policy process.

The forum on traditional knowledge and indigenous healing systems proposed a new system of governance in order to put traditional medicines and indigenous healing on par with modern biomedicine. Since traditional medicine and indigenous healing were entirely different systems of knowledge, each with its own distinctive epistemology, the system of governance must be sensitive to their philosophical differences. Using modern scientific epistemology in order to validate or to raise the standard and quality of indigenous healing systems amounted to cutting the feet to fit the shoes.

The forum on water resource management and energy policy as well as the forum on a healthy public policy advocated decentralization of public administration, stronger public participation, and more transparency in the way public policies on natural resource management were formulated.

An interesting feature of the 2003 National Health Assembly was that local themes were presented through folk performances. In these presentations, local dialects were used as the medium for voicing health issues as well as for entertainment purposes. In addition, traditional ritual ceremonies were also employed during the opening and closing sessions of the assembly. The conventional way of debate and

discussion with its emphasis on verbal expression could be viewed as favoring central Thai-speaking, well-educated middle class. Local languages and cultural performance allowed those who were not native to the central Thai dialect to be more comfortable and confident in expressing their views in the ways with which they were familiar. Joni Auodeurchao, a leader of the Karen ethnic hill-tribe remarked that the use of local languages at the convention symbolized a fresh new way of looking at health:

> There are many ways that health could be thought of. In fact, there are many healths for many people. For us Karen people, health is being able to feel confident in what you are. When you don't feel humiliated by your own culture or ethnic background, that is health.

❑ Civic Forum as a Parallel Public Sphere: An Analysis of the National Health Assembly

Twelve years earlier, on September 12-15, 1988, the first national health assembly was organized in Thailand at the Ambassador Hotel in Bangkok. This was considered by many as a landmark in health policy development in Thailand. The assembly was the first time when high-level policy makers and political leaders, not only from health, but also from various sectors outside the conventional public health domain, gathered to discuss issues facing the health of the nation. The opening ceremony was presided over by HRH Princess Sirindhorn and attended by Ministers from various ministries including the Ministry of Education, the Ministry of Interior, and the Ministry of University Affairs.

More than 1,000 participants included mostly health policy makers, administrators, researchers, and officers from various ministries. The assembly discussed and debated issues including national health policies, health manpower development, public participation, medical technology assessment, health resources procurement and allocation, and strategies for child health development. The event was considered an extraordinary achievement because, for the first time in

the history of Thai public health, it exemplified the much-praised concept of multi-sectoral collaboration in health policy development.

In 2000, twelve years after the first national assembly, another national health assembly was organized. Although organizers of the two assemblies were closely linked, the events were remarkably different. The latter assembly was attended not so much by state officials and policy makers, but by grassroots community organizations, development NGOs, professional associations, charitable foundations, and various other kinds of civil society organizations. The focus of the assembly was on the roles of local initiatives and civil society organizations in shaping and carrying forward the health reform agenda.

The shift from an assembly of decision makers in official policy processes toward non-state actors was significant, with a drastic transformation in politics and governance in the domain of the Thai health system. The national health assembly of the year 2000 became a newly invented social space in which the deliberative function of governance could be realized. The following analysis will examine the processes that brought about the new social spaces and how these served as a public sphere, a sphere by which the official politics of exclusion was challenged and transformed.

To better appreciate the significance of this newly invented public space, a brief theoretical review of the notion of public space will be provided in the following section. It will also raise a few interesting questions regarding the significance of "alternative spheres of autonomy" within the domain of health, which, in less than half a century of modern medical history in Thailand, has been transformed into a "technical sphere" predominated by professional authority and specialized medical experts. To illustrate how such new social spaces were created, a case example of indigenous healer's network will be discussed. It will be evident that the new social spaces populated by civil society organizations served not only for the valorization of civic consciousness and political subjectivity, but as a much needed deliberative function of governance in the health system.

On the Notion of Public Sphere

Studies on political subjectivities and social movement have provided insights on the change in politics from a representative democracy towards a more participatory form of democratic governance. Various studies in this field have pointed to the importance of an alternative discursive space as a prerequisite for any contestation of existing politics of exclusion. Fraser (1992), for instance, posited that "subaltern counter publics" were instrumental for those who were excluded by the mainstream political processes to be heard. Fraser's argument was based on her conception of multiple public spheres in which she argued against Habermas' thesis of a "bourgeois public sphere". In his thesis, Habermas investigated the emergence of the "public sphere" in eighteen-century Europe and demonstrated that it was a critical period of European democratization.

According to Habermas' account, the emergence of a "bourgeois public sphere" first took place in eighteenth-century Europe. At the time, trade and oversea commerce was at its height. The middle class merchants and entrepreneurs had accumulated their wealth and became politically active. The new centers of sociability found in places like salons and coffee houses, as well as the invention of printing and periodicals such as the Tatler, the Spectator, and the *Examiners* created a new social space in which the activities of the state could be scrutinized. According to Habermas this public sphere in the eighteenth-century was

casting itself loose as a forum in which the private people, come together to form a public, readied themselves to compel public authority to legitimate itself before public opinion. The publicum developed into the public, the subjectum into the [reasoning] subject, the receivers of regulations from above into the ruling authorities' adversary (Habermas 1989: 25-26).

This new sphere was created within the tension between "town" and "court." The term public had assumed a new meaning, from a narrow sense as synonymous with "state-related" to a domain of judgment. It was within this public sphere of civil society that public opinions were formed. "Whatever was submitted to the judgment of the public gained Publizitat (publicity)" (Habermas 1989: 26). The emergence of a critical public eventually led to the attainment of freedom of speech and expression. However, according to Habermas, this bourgeois public sphere went into rapid decline in the face of "re-feudalization" when the state became stronger and the press fell under the control of the increasingly commercialized system of mass communication.

Habermas' "inquiry into a category of bourgeois society" was an attempt to trace the origins of public opinion. Public sphere, according to Habermas, was a domain of social life that led to public use of reason. His idea that a consensus could be reached and public opinion formed through debate was later developed into his thesis on "communicative action." In a sense, Habermas viewed the public sphere as an "ideal speech situation" in which all participants in the public were free to debate and have equal opportunities to do so. This normative notion of public sphere was criticized by many as ignoring the unequal access and uneven ability to participate in the mainstream public among those who are marginalized and excluded.

Feminist scholars argued that women were and still are systematically excluded from the bourgeois public sphere. Fraser (1992) suggests that it was better not to consider the public sphere in a single, normative manner. In order to maintain that the public sphere was not something monopolized by the bourgeois, we must instead perceive of multiple public spheres. Notions such as "subaltern counter publics" were proposed to differentiate the public space of resistance from the dominating mainstream public sphere. In other words, public spheres were not single but always plural. In addition, among these multiple spheres of the public, there were always spaces of contestation and

negotiation in which those who were excluded and discounted by the mainstream public produced and circulated their counter discourse.

In the sphere of health and medicine where the power and authority of the medical establishment dominated, attempts to reclaim this technical sphere from medical experts took many forms. The recent movement on women and reproductive health was a forceful effort to reclaim autonomy of women from the male-dominated medical practices. The upsurge of alternative medicines was another instance of such reclaiming of technical sphere. This chapter explores how these alternative spheres of autonomy were created in the process of health systems reform. Such alternative spaces served the deliberative function of governance that has so far been absent in the existing structure of health system administration.

❑ Civic Forums and the Alternative Sphere of Autonomy

The creation of civic forums and community meetings was crucial in the process of engaging various sectors of society in the reform movement. This was particularly evident in the case of indigenous healers, who, for the most part of Thai medical history, were left out and ignored by official policy and authority. The following section provides a detailed analysis of the indigenous healers network to illustrate how civic forums as an alternative sphere of autonomy could serve as an arena for the realization of political subjectivity.

The Case of Indigenous Healers Network

Since the introduction of modern medicine in Thailand, indigenous healing traditions have been on the wane. Various forms of indigenous healing have been struggling for survival with little policy support from the state. Among the variety of indigenous healings, only the classical medicine of the central Thai has been legally accepted, albeit with little support. The variety of "indigenous healing" and "ethno medicines" from other cultural backgrounds did not receive an equal opportunity. If "Thai

traditional medicine" could be said to be marginalized by modern medicine, "indigenous medicines" were even more so; they were struggling at the outer margin with little recognition and support from the state authority.

Practitioners of traditional medicine must pass a licensing examination in order to practice traditional medicine. However, this examination is based on specific medical textbooks that are mostly about the classical Thai system of healing. Indigenous healers from different ethnic and cultural backgrounds are hardly able to pass the examination on the basis of their distinctive systems of indigenous knowledge. Without a license allowing medical practice, indigenous medicines were discarded and their systems of knowledge increasingly irrelevant. It was within this context that indigenous healers in various regions in Thailand found that the health systems reform movement might serve as an instrument for the revitalization of their indigenous systems of healing. This case study examines the effort of indigenous healer organizations to make their voices heard and to shape the legislative framework of the new pluralistic national health system.

Origins of the Indigenous Healers Network

Efforts to revitalize indigenous medicines started in the early 1980. The Herbal Medicine for Self-Help Project founded by Komol Kheemthong Foundation, a high profile non-governmental organization, and the Traditional Massage Revival Project by Foundation for Health and Development were among the pioneering attempts. At the time, there was a movement among non-governmental development organizations to strengthen and encourage the use of "local cultures" and "indigenous systems of knowledge" in community development work. Collaboration between developmental agencies, researchers, community health workers and indigenous healers in northern Thailand culminated in the *"Association of Indigenous Healers of Phya Mengrai District"* in Chiang Rai. In the following years, further collaboration with neighboring Phayao expanded the organization into the

"Association of Indigenous Healers of Chiang Rai and Phayao Provinee,"the first indigenous healer organization with members and activities transcending provincial borders.

The AIDS epidemics that severely hit northern provinces in the 1990s brought public attention to the association. Witnessing the mortality of AIDS victims who were left without any effective remedy, indigenous healers offered what they perceived as possible remedies for the sick. Northnet Foundation, a non-governmental organization, was one of the early efforts to organize indigenous healers in order to provide what was seen as "holistic care" for people with HIV/AIDS. Within a span of two years, forty more of such indigenous healers' organizations were established. The urgent need to rescue their fellow villagers from life threatening disease made it necessary for indigenous healers to share and exchange their experiences. This necessity not only greatly enhanced the networking of indigenous healers but also lent a great degree of legitimacy to the revitalization of indigenous systems of knowledge.

In the northeastern region, the effort of non-governmental development agencies to conserve natural forests brought to attention the importance of herbal medicine. In the past, there had been isolated efforts to promote the use of herbal medicine by individual healers. The support from non-governmental development agencies helped to connect them and encouraged collective action. In the late 1990s, 250 indigenous healers from seventeen provinces met in Mahasarakam Province to form the "Council of Northeastern Indigenous Healers." The aims were to create a forum for exchange of ideas and information as well as to increase their roles and visibility among the public. The council, consisting of twelve associations of indigenous healers, has since been actively advocating indigenous healing and herbal medicine. Cooperation with the provincial health authorities and research institutions further enhanced the roles and strengthened the networks of collaboration among indigenous healers.

Associational Power: Shaping the National Agenda

Through their participation in various collective activities, indigenous healers gradually learned how to further strengthen their effort in revitalizing indigenous healing. In the past, their associational life was mostly confined to their local communities. When they came together and discovered broader issues of common concern such as legislative problems, policy hindrance, or deforestation, they felt the need to get organized. The new socio-political situation demanded an extension of the scope of their associational life. With the assistance of non-governmental development agencies, organizations of indigenous healers expanded their roles from providing support to their members to advocacy.

When the movement toward health system reform began in 2000, a network of associations of indigenous healers was already making a start. A group of researchers was commissioned to work with indigenous healers on a situational analysis and to propose recommendations for reform. Three meetings were organized in the north and the northeast in which more than 100 participants including indigenous healers, community development workers, health officers, and researchers convened to discuss how to include the revitalization of folk healings and local indigenous medicine (and not just Thai classical medicine of central region) into the reform agenda. The consultation resulted in four main recommendations:

1. Existing potentials of pluralistic medical systems must be recognized and further developed to make them useful and able to work together for the health of people.
2. Decentralization is a prerequisite for the revitalization of indigenous medicines. It will enable local authorities to adopt and adapt locally available indigenous medicines to suit local needs.
3. Local communities must maintain their rights to preserve and revitalize indigenous medicine and local systems of knowledge as well as to manage, develop, and make use of local indigenous medicine and medicinal herbs.

4. The government must designate a "National Committee on the Development of Thai Indigenous Health Systems" under the National Health Council to direct policy and be responsible for the support and improvement of indigenous medicines.

Civic Forum, Story Sharing and the Politics of Collective Empowerment

Although sometime is needed to convince the national health authority to accept such recommendations, the process of deliberation was the first time indigenous healers came together and collectively realized their common predicaments and purposes. The forums and public deliberation of policies toward indigenous healing became a venue in which their political agenda was conceived. While the mainstream political sphere was unavailable to these indigenous healers, these discursive spaces enabled them to reclaim their autonomy, to speak for themselves, and to transform themselves from object being acted upon into subject acting upon the world. By sharing their stories in working to revitalize their indigenous system of knowledge, local healers determined the problems they were working against. A story recounted by an indigenous healer of the northeast region provides an example of how he worked against the system, which was structurally detrimental to the indigenous system of knowledge:

> A few years ago, I set up a school of indigenous knowledge in my hometown in a northern province. I reported to officialdom because I wanted the school to be properly registered. Governmental officials came to me and asked if my school had enough room for students and teacher's offices and courtyard for student. They also wanted to know what the teacher and student ratios are. Are the teachers qualified and do they have teaching license? I said my school is different from an ordinary school because we are teaching in our indigenous ways. The

> official said it is illegal to set up a school without complying with the state's regulations. If I wanted to call it a *"rong rian"* [a school], I had to conform to the state's regulations. I figured out my school couldn't operate that way and decided to call it by the local term for a school, *"hong hian,"* instead of in official central Thai language *"rong rian,"* just to keep it away from the prohibitive law.

The rules and regulations may be appropriate for modern system of schooling, but indigenous apprenticeship and schooling was an entirely different affair. Because state legislation regulated only *"rong rian,"* they did not apply to his *"hong hian."* By changing the name to local dialect, he was free to operate without being subject to the state rules and regulations, while he could maintain his indigenous identity at the same time. The school has been operating since and providing apprenticeship not only for indigenous healing but also for indigenous music and performance, woodcraft and sculptures.

The sharing of stories and narratives was particularly meaningful among those whose political existence was excluded. One of the main questions asked in the forums of indigenous healers was "Why is health an exclusive domain of modern medicine and the state?" In the processes of exchanging ideas, it became increasingly apparent that the fading of indigenous medicine was not because it was less effective. There were a number of ailments that indigenous healing could in fact complement modern scientific medicine. The problems were much more subtle.

The domination of modern medicine is not only embedded in legislation, state policies, and in the way the national health system was organized, but also in the language, explanation, and classificatory scheme tightly entwined in the social stock of knowledge. An indigenous healer said in a seminar, "When we use foreign terminology, we are not only using a term but we are also employing their way of

thought." Others added, "Those who hold the explanation hold the power." It was not surprising that most of the forums of indigenous healers were held in local languages to challenge the imposed power of the official language. Within this alternative discursive space in which the dominant discourse lost its commanding power, indigenous healers reclaimed their ability to speak for themselves.

Forums and meetings among indigenous healers, developmental agencies, and local health authorities also reduced the tension among the groups. Dialogue and informal exchange greatly enhanced trust and reduced intolerance. In the past, encounters between indigenous healers and state health officers often resulted in dissension due to mistrust. Many indigenous healers were prohibited from practicing their arts of healing because local health authority considered them as illegal and superstitious. After a period of regular meetings, there was an increase in mutual understanding. The rigid application of rules and regulations against indigenous healing has gradually relaxed. Indigenous medicine for self-care, complementary care and psychosocial support, and healing practices performed by members of recognized associations, for instance, has become more acceptable. In a sense, there was a trusting relationship developed out of informal exchange and dialogue. This trust, which some theorists consider as a form of social capital (see Coleman 1988; Putnam 2000), enabled further collaboration and collective action.

❑ The Challenges: Facing Controversies, Creating Consensus

Although the aim of the deliberation was to build consensus, the process also raised a number of controversial issues, three of which were of particular importance. One of the controversial issues was the notion of spiritual health. As an attempt to expand the working definition of health, it was suggested during the drafting of the bill, that health should be defined as "a dynamic state of complete physical, mental, social, and spiritual well-being" instead of merely "a complete

state of physical, mental and social well-being". There were some scholars, monks, and representatives from religious organizations who did not feel comfortable with the use of the Thai term *"sukhapawa tang jitwinyan"* or "spiritual health" in the new definition of health. Their concern was that the Thai term *"jitwinyan"* which is generally employed to mean "spirituality" was allegedly inconsistent with the Buddhist etymology. Discontented groups participated in the assembly and strongly protested against the use of such terminology. They wanted to remove it from the legislation and use other terms instead. Other religious groups as well as many other Buddhist groups had no objection to the term.

As the term *"sukhapawa tang jitwinyan"* has become increasingly recognized and accepted by various civic and religious communities, the dispute posted a dilemma for the National Health Systems Reform Committee. It has been generally agreed that a concept such as spiritual health was much needed to signify a crucial dimension of well-being overlooked by the conventional health concept. However, on the one hand, after a long and persistent attempt to encourage the use of such concept, the term *"jitwinyan"* has been relatively accepted and fairly successful in conveying the message across both secular and non-secular sectors. On the other hand, it was considered offensive to a group of devoted Buddhists. How could this dispute be resolved? Voting was not considered an appropriate way to reach consensus. Employing a non-confrontational, peaceful conflict resolution, the National Health Systems Reform Committee proposed to organize a consultative workshop to resolve the problem.

Representatives from various religions were invited to seek an appropriate solution at a meeting chaired by a well-respected member of the Privy Council. In the consultation, the chair began by reminding everyone that the aim of health systems reform was to enhance the health of the nation by working together. Attempts should be made to work out any conflicting ideas and to reach consensus, but at the same time respect and tolerance towards diversity and differences was also critical.

Everyone was invited to express their pros and cons on the use of *"jitwinyan"* as a conceptual term. Participants were also invited to propose alternative terms for the concept. A number of terms were suggested and the meeting debated on each term. By the end of the process, the consultation came to the conclusion that the term *"jitwinyan"* should be replaced by the word *"panya"* or "wisdom". Although those using the term *"jitwinyan"* were disappointed, they agreed on the use of a new term that could be embraced by all. Once the agreement was reached, the new term was proposed to the legal body to be used as a substitute.

The other two controversies concerned the issue of death and dying and the for-profit health care industry. In the case of death and dying, controversy emerged from different interpretations of an article in the draft bill stating that everyone has the right to "die in peace with human dignity" (article 24, Draft of National Health Act). Hearings were organized to clarify the issues, but consensus was elusive. Yet such subtle processes of consultation created an environment that enabled each party to respect and learn from the different perspectives. The point of the deliberation and public debate was not just to finalize or settle a dispute, but more importantly, it was a collective learning process for civil society to appreciate the dialogical nature of decision-making that would enable a win-win solution.

III. Political Engagement for Legislative Reform

❑ Active Citizens and Official Authority: Defying the Medical and Political Model

Conclusions from the forums clearly demonstrated the potentiality of health as an issue in which civic associations and grassroots communities could work together to realize their collective capacity. Most suggestions and conclusions aimed at changes in a broader context and macro-social policy instead of viewing health from an individualized and medical viewpoint. It is noteworthy that it was the official authorities and medical establishments that could not follow the conclusions and suggestions from civic forums. Official representatives from the health bureaucracy were at a loss when invited to express their views. Ministerial representatives often viewed participants as "lay persons" passively awaiting "health experts" to tell them what to do. They often tried to use the forums to "educate" participants.

A representative from the Minister of Public Health, for instance, was invited to give his response to the conclusion from the forums. Instead of acknowledging and responding to the ideas proposed by the forums, he used his thirty minutes to teach how one should eat clean food, exercise at lease twice a week, get enough sleep at night, and avoid being emotional in order to stay healthy. An official from the Ministry of Agriculture was quite taken aback as participants presented the problems of excessive use of agricultural chemicals and asked his opinion on banning the import of agricultural chemicals. He said he did not expect to be asked such a serious question. Another high-ranking health official tried to argue how successful health development has been in the past and how, in order to achieve more, people should feel grateful and comply with what state officials say.

While civic politics attempted to redefine health and establish an active role for citizens, official authority was trying hard to retain the existing biomedical model of health and the non-participatory model of

politics. Health was perceived and deliberated in the forums not so much as individual health achievable solely by adopting a healthy lifestyle and passively following official authority. Rather, health was viewed as socially determined, and public policies that greatly affected health were too important to be left to bureaucrats, politicians, and experts. It was the shifting of the view on health and politics from the conventional model to one that expanded the definition of health and embraced an active role for citizens that could be said to be the true object of reform.

❑ Engaging the Political Establishment: The New Political Environment

During the three years of the reform process, representatives from various political parties, politicians and members of the House of Representatives were invited to participate in workshops and conferences. The National Committee on Health Systems Reform, chaired by the Prime Minister was expected to serve as a critical link between public deliberation and the official policy process. The ultimate goal of drafting a national health bill and gaining approval by parliament made it imperative to engage official politics and involve the political establishment. In the course of the reform, however, a delayed the legislative process.

The first general election after the new constitution became effective resulted in a government drastically different from earlier ones. Thaksin Shinawatra, a telecommunication tycoon and head of the newly founded Thai Rak Thai Party, became prime minister after a convincing electoral victory in early 2001. The party's populist policies, which gathered support from various social strata and sustained the popularity of his administration, expanded the role of the state beyond previously conceptions. In the first year of the Thaksin regime, the government constructed low price housing and condominiums for sale to low income people, sold economically priced desktop and notebook computers, provided low cost life insurance, set up a community fund for

loans, subsidized small and medium sized enterprises, and provided universal access to health care.

While the state was currently expanding its role as a welfare state, the business and economic sectors were boosted by Thaksin's dual track economic policy, known in a self-aggrandizing term, "Thaksinomics." The approach was a simultaneous two-pronged strategy of strengthening local economies through promotion of small and medium sized enterprises and local communities' products along with greater expansion of exports, inviting more foreign direct investment, and the creation of global strategic partners. The approach proved successful with GDP growth exceeding estimates.

While the new government's record on economic development was generally favorable, its record on social and political development was relatively less impressive. The human rights record came under critical scrutiny when thousands went missing in the war against drugs led by the government. Some were reported to have been executed without legal trial. Those who did not agree with certain aspects of state policies were roundly criticised and accused of bad faith. Politically active non-governmental organizations critical of state policies were accused of being paid by ill-wishing foreign agencies to blemish government credibility. Academics criticizing the way the country was run and the conflict of interest in the government were ridiculed by Prime Minister Thaksin. Some were threatened in mysterious phone calls. In this new political context, the expected role of civil society organizations was to comply and cooperate without questioning the rightfulness and lawfulness of state policies, or so it seemed.

❑ The Way Forward: Beyond Representative Democracy

Although Prime Minister Thaksin Shinawatra presided over the closing ceremony of the National Health Assembly in 2001, and promised to process the draft bill through parliamentary approval, some

changes in the bill worried him. As a Premier with a strong entrepreneurial ideology, an article in the bill prohibiting capitalist exploitation of health care was perceived as contradictory to governmental policy. In addition, bureaucrats and professional politicians also opposed some structural changes that were viewed as detrimental to the status quo. However, the draft bill was approved by the National Health Systems Reform Committee in the middle of the third year of the reform plan. In December 2003, however, the bill was delayed while waiting to be considered by a screening body before submission to the Cabinet.

To avoid pressure from the National Health Systems Reform Committee and its wide-ranging civic alliance, the government extended the reform plan from three years to five years by extending the work period for the National Health Systems Reform and the Health Systems Reform Office. Although an extension was welcomed by many civil society organizations, a number of politically active civil society organizations became more skeptical of the government. New ways and means to pass the bill through Parliament were sought. Strategies to engage politicians and member of the national Parliament were discussed. Leaders of the reform were in the process of negotiations with the government.

One important development was a campaign launched to gather popular support for the bill. According to the new Constitution, ordinary citizens can propose a bill directly into the parliamentary process. Although the procedure requires 50,000 signatures, the organizers of the campaign expected to get 500,000 signatures to show strong support from the public. The closing stage of the campaign would coincide with the general elections in 2005. The civic network was not very optimistic about the outcome for the bill, but several argued that the oucome was less important than the process as part of the effort to achieve a truly democratic form of governance, and to create structures of associational life and norms of civic community. At this historical

stage of Thai political development, civil society is not so effective in the domain of the official policy process and party politics. But challenging the exclusivity of the official policy process was an important strategy to create alternative social spaces for political action by common citizen.

❑ Civic Politics, Deliberative Democracy, and the Alternative Social Spaces

Civic forums and the national health assembly can be viewed as social spaces in which ordinary people could realize their political potential. These forums drew together people from various civic communities and helped them to elaborate on their common purposes, to negotiate their interests, as well as to assert their autonomy. It was through their discursive participation within this alternative political sphere that individuals were transformed into active citizens. Such alternative spheres of autonomy require distinctive terms of engagement in which differing opinions are not only tolerated, but also acknowledged with a strong collective conviction that only through dialogue and reciprocity can humankind learn to achieve collective well-being. By engaging civil society in the deliberation, health system reform was firmly grounded in a solid civic foundation.

In the transition from representational democracy to direct democracy in which citizens take active roles, reform processes need to provide people with an opportunity to participate, to deliberate on problems, and how they should be viewed, the relevant policies and best method to implement these policies. Such deliberation must be carried out under conditions that are unfettered by the dominating power structure. Community meetings, civic forums, and assemblies provide alternative public spaces in which citizens can make a difference in how the health system should be configured. The reform process was a step toward the realization of deliberative democracy.

Deliberative democracy, as the Civic Practice Network succinctly states on their website:

> rests on the core notion of citizens and their representatives deliberating about public problems and solutions under conditions that are conducive to reasoned reflection and refined public judgment; a mutual willingness to understand the values, perspectives, and interests of others; and the possibility of reframing their interests and perspectives in light of a joint search for common interests and mutually acceptable solutions.

The alternative public spaces created by various civic forums were useful not only for the deconstruction and reconstruction of the concept of health and the health system. They were instrumental as a civic educational tool, a tool by which communities could come together and learn to become active citizens. It was through this learning process that a shift from a previously unaware political subject into a self-conscious civic actor with a public mind took place. Again, as the Civic Practice Network puts it:

> It is thus often referred to as an open discovery process, rather than a ratification of fixed positions, and as potentially transforming interests, rather than simply taking them as given. Unlike much liberal pluralist political theory, deliberative democracy does not assume that citizens have a fixed ordering of preferences when they enter the public sphere. Rather, it assumes that the public sphere can generate opportunities for forming, refining, and revising preferences through discourse that takes multiple perspectives into account and orients itself towards mutual understanding and common action (http: www.cpn.org).

In looking at how a sense of active citizenship was realized, we can see from the examples above that building a deliberative democracy required the construction of a new discursive space, a venue that helped to transform persons into active citizens. Civic forums and community meetings created a much needed space for individuals to come together and realize their collective actions. It was this transformation from an isolated, individualized life into an associational life of active citizenship that was the core of the health systems reform movement in Thailand.

5
Conclusion and Recommendations

Reform as the Deliberative Construction of Active Citizen

❑ Lessons Learned

With the end of the Cold War and the collapse of faith in revolution as a route to political change, there has been a new debate on strategies to induce radical change in advanced capitalist societies with strongly entrenched state formations and powerful vested interests. One approach to this issue has developed from the ideas of the Italian Marxist, Antonio Gramsci. In theorizing on the revolution in Europe, Gramsci pointed out that in advanced capitalism, political control is achieved as much through popular "consent" as through "force." Based on this insight, Gramsci distinguished two fundamental forms of political power: "domination" (direct physical coercion) in the realm of state, and "hegemony" (consent, ideological control) in the realm of civil society (Boggs 1976:39). The development of skilled labor, the role of mass media, the availability of more sophisticated techniques of ideological control, the importance of knowledge and education in advanced capitalist societies, all required the state to increasingly build its authority upon hegemony rather than force.

Instead of challenging "domination" through Lenin's "war of movement," Gramsci proposed a "war of position" to challenge and modify "hegemony" as a main strategy for social change in advanced capitalist society. By "war of position", Gramsci meant a long-term contestation of cultural-ideological hegemony in order to shift the equilibrium of social forces. Politics in Gramsci's sense was thus more "moral-intellectual" and "cultural-ideological" rather than "political" in the narrower sense of struggle for seizing state power.

In recent years, many proponents of social change have theorised "civil society" as the site for such wars of position. Civil society is the place where views of "the good life" can be debated without succumbing to an old polarization into left and right. The civil society argument, as pointed out by Michael Walzer (1992), "is directed as a critique of both the left, which was too wedded to government action in the pursuit of distributive justice, and the right which was too unconcerned with the destructive impact of competitive markets on the fabric of associational life."

This report provides an account of civil society and health system reform in Thailand to demonstrate how a broad-based civic movement was brought into being. From the review and analysis above, we can see that the meaning of civil society is contingent on the historical and political context. In the case of Thailand, the changing international context and the evolution of Thai politics over the past few decades were relatively conducive to the growth of non-state actors. The emerging public sphere has been increasingly populated by civil society organizations of various shapes and sizes. As defined at the outset of this report, civil society in the current situation in Thailand could be thought of as "an autonomous sphere of social interactions in which active individuals and groups form voluntary associations and informal networks and engage in activities with public consequence."

In the three years of health system reform, activists aimed at creating a broad-based reform movement to achieve two strategic objectives: (1) The restructuring of institutional infrastructure through legislative action, and (2) The forging of a new collective health consciousness. The analysis of the reform process suggests that the most important aspect of mobilizing civil society in health system reform was the creation of a process of civic deliberation. Various forums, meetings, conventions, and conferences at different levels created much needed venues for the public to deliberate how health should be understood and what changes were needed to achieve a desirable health system.

In order to engage the broadest range of social actors and civil society organizations in the reform process, it was realized that the concept of health itself needed to be expanded from a biomedical concept towards a more holistic, inclusive, and multidimensional definition. Health in the reform process has been redefined to emphasize not only biological and psychological aspects but, more importantly, social and spiritual aspects of well-being and wellness. The broadened concept of health enabled the involvement of a wider range of stakeholders in the deliberation process.

It was in the deliberative processes that active citizens were empowered, the seemingly unproblematic status quo called into question, and a new meaning of health was generated. Health, as it was perceived and deliberated in civic forums, was not so much an individualized, depoliticized state achievable solely by individuals adopting a personal, healthy lifestyle and passively following official authority or bureaucratic policies. Rather, health was viewed as socially determined and inseparable from collective well-being and social justice. Public policies that often greatly affect health were viewed as too important to be left to bureaucrats, politicians, and experts. It was this shift in the view of health and politics away from conventional models to ones that expanded the operational definition of health to embrace the active roles of citizens that could be said to be the true object of reform in the Thai health system reform movement.

❑ Recommendations on Enhancing the Roles Civil Society in Health Policy and Action

Expanding the Framework of Health

The biomedical definition of health cuts off health from wider issues of social and economic development and poverty alleviation. The expansion of the operational definition of health in health sector reform from a disease-oriented, curative approach to a more holistic approach

will broaden the scope of possible participation of civil society. Framing the reform process from the perspectives of health promotion and caring of chronic illnesses will reemphasize the role of family, community, neighborhood, and other grassroots organizations. A new concept of health expanded to include multiple dimensions of health can facilitate further cross-border collaboration. Expanding the concept of health is thus a prerequisite for broader participation of health reform.

Pluralized Policy Processes and Actions

Most health reform efforts rely on what can be called the "official policy process" in which the process of policy formulation, planning, and implementation of the national health reform policy are undertaken exclusively within the public health bureaucracy. As pointed out by Jareg et al, the grand vision of "Health for All by the Year 2000" launched by WHO in 1978 could never be fulfilled by governments working alone. NGOs, with their experience of working with the dispossessed and groups difficult to reach, had to be the core alliance to accomplish such an important goal. The same can be said for health reform. Civic engagement and public deliberation of health reform can be useful to overcome the limitations of official politics and representative democracy. This is a move that will broaden the platform in which civil society and active citizens can participate more directly and variously in public affairs.

Encouraging Collaboration between Civil Society and National Agencies

Experiences from the health systems reform movement in Thailand strongly suggest that collaboration between civil society and the health reform agency was critical. This cross-border collaboration has to transcend differences in organizational cultures. Various actions could be taken to promote this cross-cultural collaboration between them.

Coordinating Mechanisms

Focal points for the coordination of civil society organizations are needed to facilitate the collaboration. Sigrun Mogedal of Center for Partnership in Development offers this practical remark on collaboration and partnership between government, corporate society and civil society.

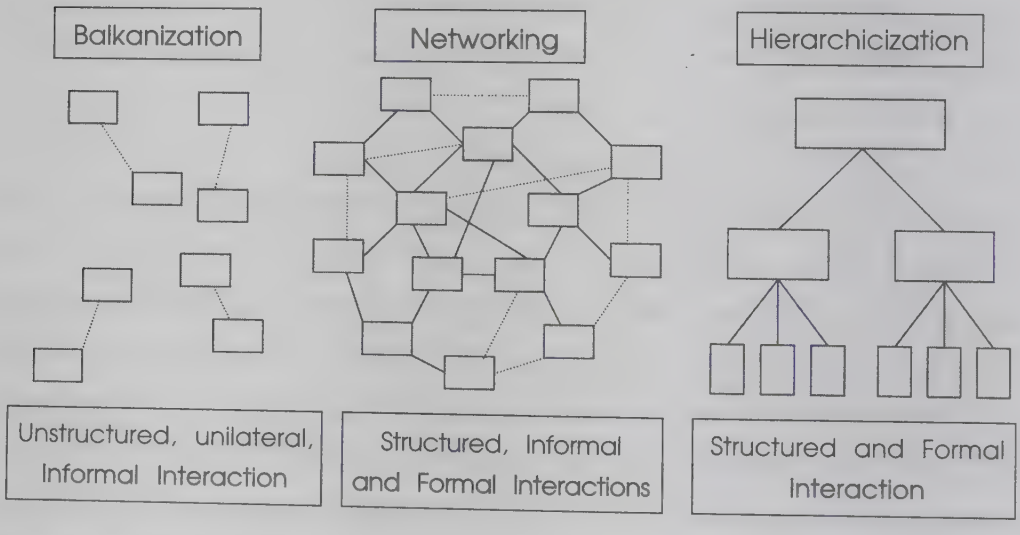
> Partnerships between civil society, governments and donors for agreed purposes can also obviously be constructive and effective, but may represent constraining co-option and should not by design be understood to be harmonious. Civil society cannot easily become contracted by any outside agent of development and change without loosing its specificity and potential. Community mobilisation and organisation in free democracies can be enabled but not prescribed (Mogedal 1998: 8).

Collaboration and coordination between organizations can take various forms, ranging from a rigid top-down bureaucratic relationship on the one hand, to a loosely structured network on the other. In civil society, where voluntary organizations are mostly autonomous, relationships between organizations are fluid and informal. Forms of collaboration and coordination can be grouped roughly into three models of interaction and linkage: balkanization, networking, and hierarchicization (see diagram below).

Among these models of inter-organizational relationships, networking has become a common mode of collaboration and coordination in civil society. Balkanization refers to inter-organization linkages in unstructured and informal ways. Each organization maintains its own autonomy and interactions are mostly bilateral. Networking refers to interactions and linkages between organizations both formally and informally. Inter-organizational networking is

usually not bilateral and involves more than a few organizations. Each organization might have its own objectives but come together in order to set a common agenda or to accomplish certain tasks.

Hierarchicization refers to formal and structured ways of interaction between organizations in which organizations lower in the hierarchy are under command and receive orders from higher organizations, a typical bureaucratic relationship. Interaction and linkage in civil society fall mostly into the networking model. Before formal collaboration and coordination can be reached in civil society, trust, acquaintance, and a sense of shared purpose must first be established through informal engagement (Bebbington & Farrington, eds. 1992).



(Three Models of organizational interaction and linkage. Adapted from "Alternative Models for Intercommunity Governance," William R. Dodge 1992: 406-407)

Information System

Creating an information base to facilitate the cooperation with civil society is crucial particularly where little coordination previously exists. Building an information base of civil society is, however, not the cataloging of civil society organizations or listing their addresses. A strategic information base does not only consist of sets of data on each organization, but, more importantly, the strategic linkages and key connections each organization has and the common goals shared by a cluster of organizations. Compiling this strategic information cannot be accomplished simply by looking into the directories and annual reports of the organizations. Rather, it should be done by actually participating in the activities carried out by these organizations to understand the organizational culture of civil society organizations.

Encouraging Dialogue between Civil Society and International Agencies

As countries are increasingly incorporated into the global economy, local civil society organizations will need to work more closely with transnational civil society organizations. Greenpeace, World Wildlife Foundation, Transparency International, for instance, have set up their regional and country offices in many parts of the world. At the same time, with the global regime of free trade, transnational corporations have increased their presence in every region. Just as with politics and economics, health has become simulta neously a global as well as a local issue. It is more crucial than ever for local civic initiatives to coordinate and form networks, not only with transnational NGOs, but also with other global institutions. Linking local NGOs initiatives to the global agenda needs continuous dialogue between agencies in the UN system, multilateral financial institutions, and funding agencies. These global institutions have different strengths and weaknesses as the table by Gill Walt illustrates.

Organizations	Perceived Strengths	Perceived Weaknesses
World Bank	Financial resources, policy advice, and technical assistance Links to ministries of finance and planning	centralized, weak country offices (staff in Washington) narrow economistic approach to health perceived as Western dominated and ideologically driven
UNICEF	effective at operational level resources at country level ng country offices (85% staff at country level) advocacy role	too driven by New York and narrow goals sustainability of initiatives approach vertical to health
UNFPA	resources strong advocacy role (family planning) limited technical capacity effective procurement service	small, undergoing paradigm change from rigid population control to reproductive health subject still vulnerable to political differences
UNDP	broad development orientation close ties to government coordination role	diverse competence at country level poor on advocacy because of ties to government
WHO	technical and scientific knowledge network of experts links with ministries of health	weak at country level two-third staff (of 5700) at central or regional level

Source: Gill Walt 1996:28

The roles of international NGOs and the emerging global civil society are increasingly prominent. International NGOs can help raise global awareness and monitor the compliance of corporations and nation states on various issues. Baby Milk Action, for instance, works to promote legislation and practices in line with the WHO's International Code of Marketing of Breast Milk Substitutes. Other organizations perform different roles such as challenging international financial institutions or development agencies to rethink their policies and practices. These different forms of interaction and relationships can be more constructive by encouraging continuous and open dialogue between the different perspectives.

Promoting Research

Civil society and other related concepts are new, and the theory of civil society and health is still in its infancy. Although it seems to be a useful conceptual tool, the concept which emerges from specific historical contexts needs to be adapted to local settings. Information necessary for policy formulation and a cooperative effort is difficult to find. Promoting civil society and health as a field of research inquiry will help to create a much needed knowledge base for further collaboration.

Research Questions

Research studies are needed to build up the knowledge base in order to enhance the roles and performance of civil society in health. The following recommendations are four groups of research questions, which are important to refine the idea of civil society, assess the profile of civil society, and configure the relations of civil society and health. The four groups of questions are on: theory of civil society and health; basic information and profile of civil society organizations; strategies and approaches in broadening the alliance for health in civil society; and tools and technical know-how in strengthening civil society.

- **Theory of civil society and health**

1. What are the differences in the definition of "civil society" among different schools of thought and political ideology? What practical implications do these different theoretical orientations have in the relationship of civil society and health?
2. As a concept derived mainly from Anglo-American political thought, how can the concept of civil society be applied in non-Anglo-American contexts and how useful is this "foreign" concept for strengthening participation of various sectors in health development in developing countries?
3. What are the basic assumptions that inform existing policies, plans, and actions in health development? How can the concept of civil society help as a corrective measure for the existing policies and practices in health development?
4. What is the theory of health development and how can "health" and "health system" be defined in ways that are more inclusive and open to civic participation?
5. What new theoretical and conceptual understandings can be generated and synthesized from lessons learned from various civic movements (such as environmental conservation, women's movement and human right movement) worldwide and how can they apply to health actions?

- **Basic information & profile of civil society organizations**

1. What are the existing civil society organizations (e.g. community organizations, people organizations, voluntary associations, and non-governmental organizations, etc)? How many and which of the existing organizations are active?

2. What is the geographical distribution of these organizations? How are these organizations distributed in various areas of interest and in different areas of health problems? Which areas of social policy and action could civil society organizations have strong or weak roles or contributions?
3. What are the existing coordinating mechanisms between the health sector and civil society? How effective are the existing coordinating mechanisms?
4. Through which existing mechanisms is civil society related to governmental agencies and corporate society?

- **Strategies and approaches in strengthening the roles of civil society**

1. What are the strategic problems in the existing health development paradigm? How can the idea of civil society as a strategy be applied to broaden participation and multi-sector cooperation for health development?
2. What are the strategic alliances in different areas of health development? What can be done to create strategic relationships among these alliances?
3. What are critical linkages or interfaces between governmental organizations and civil society organizations in specific areas of health problems? What can be done to strengthen the linkages and interfaces? What are the alternative organizational forms that could better facilitate collaboration?
4. What are the "leverages" by which civic initiatives can be scaled up and linked to the national and global agenda?

- **Tools and technical know-how in strengthening civil society**

1. What are the existing tools and techniques for the assessment and evaluation of the roles of civil society organizations in the realm of health development?
2. How effective are the available models of civic education? In what settings are various forms of civic education most effective?
3. What are the strengths and weaknesses of the available community organizing tools such as Future Search Conference, AIC (Appreciation, Influence, Control) method, Consensus Organizing Model, and other soft techniques used in community organizing activities?
4. What are the training needs of various categories of health workers, which will help facilitate cooperation in civil society? How many training packages are needed for different settings of health development?

❑ Concluding Remarks

Civil society, and other related ideas and concepts, can open new ways of thinking about social change and thus new possibilities for public participation in development. But it should not be seen as a "magic bullet," capable of solving all problems in health and human development. It seems, however, that the world is currently witnessing dramatic changes in both local and global political landscapes. The current political ethos is characterized by increasing public demand for democratic governance and the increasing roles of civil society in shaping development policies and practices. Health, as an integral part of human and social development, is an excellent ground to cultivate new forms of collaboration and to enrich civil society's creative and innovative capabilities, and has already demonstrated initial potential. However, with its strengths, civil society also has its weaknesses. It is only in working together with mutual respect that the government, corporate society, and civil society can learn from each other, realize their strengths and weaknesses, and reach their distinctive potential.

To imagine a greater role of civil society in health care is to change the way we think about health and public affairs. David Korten, in his analysis of global civil society, maintains that the emerging roles of global civil society involve an unfolding of cultural struggle. The fight is not a struggle to change the way wealth (or commodity) is distributed, but a struggle to fundamentally change the ways we think about good society. As Korten succinctly states,

> Although the public face of the struggle is political, its roots are cultural and its resolution will depend ultimately on the outcome of a deep global shift in cultural values-of which the global democracy movement is one manifestation (Korten 2000).

The same can be said about health reform. Current approaches in health sector reform cast the debate in the rigid framework that reduces health to medical service and reduces citizens to passive clients awaiting services handed out to them by "health care providers." Health from a civic perspective requires a new way of thinking about health and how we bring about changes in our collective well being. From a civic perspective, health care reform is not about making a decision on an either-or choice between health as a public good provided by the market and health as welfare provided by the state because at both ends of this spectrum health care is still viewed as a commodity (a service) to be dispensed and consumed by subdued individuals. Instead of viewing health as commodity or service, we need to view health as "a state of individual and communal wellness and well-being, a state attained both through actions one takes in life and through relationships, structures, and communal fabric that connect people" (Jennings and Hanson 1995: 9). The shift of our fundamental understanding of health is a prerequisite to the new possibility to unleash the potentials of civil society in creating a healthier personal and communal life.

References

Amara Phongsapit. 2002 (2545). "Nonprofit Organizations in Thailand." (in Thai). A research report submitted to Thailand Research Fund. Social Research Institute, Chulalongkorn University.

Anek Laothammatas. 1992. *Business Associations and the New Political Economy of Thailand*. Boulder, Westview Press.

Anheier, Helmut K., and Wolfgang Seibel, eds.1990. *The Third Sector: Comparative Studies of Nonprofit Organization*. Berlin & New York: Walter de Gruyter.

Anuchat Puangsamlee and Krittaya Achawanijkul. eds.1999 (2542). *Civil society movement in Thailand* (in Thai). Salaya, Nakornpathom: Mahidol University.

Asad, T., Ed. 1973. *Anthropology & the Colonial Encounter*. Atlantic Highlands, N.J., Humanities Press.

Babblio, Norberto. 1988. "Gramsci and the Concept of Civil Society." In J. Keane, ed. *Civil Society and the State: New European Perspective*. London: Verso.

Bamrasnaradur, Phra.1957 (2500). "History of Ministry of Public Health." (in Thai). In *Commemoration of 15 years of Ministry of Public Health*. Bangkok: Phra Jan Press.

Barber, Benjamin R. 1995. "The Search for Civil Society." In "Rebuilding Civil Society, A Symposium." from The New Democrat 7(2) (March/April), available online at: www.cpn.org/sections/partisans/perspectives/new_democrat/rebuild_civil_society.html.

Bebbington, A.J., and J. Farrington. 1992. *The scope for NGO-government interactions in agricultural technology development: an international overview*. London: Agricultural Research and Extension Network.

Bell, Daniel. 1989. "American Exceptionalism Revisited: The Role of Civil Society." *Public Interest* 95: 38-56.

Benjamas Siripat and Suraphol Mulada 2002 (2545) *NGOs: Grassroots Development Agents* (in Thai). Bangkok, Arthit Product Group.

Ben-ner, Avner and Benedetto Gui, eds. 1993. *The Nonprofit Sector in the Mixed Economy*. Ann Arbor: The University of Michigan Press.

Bernhard, Michael. 1993. *The Origins of Democratization in Poland: Workers, Intellectuals, and Oppositional Politics, 1976-1980*. New York: Columbia University Press.

Beyer, C. 1907 "About Siamese Medicine." *Journal of Siam Society* 4 (1).

Bhabha, H. 1985. Signs Taken for Wonders: Questions of Ambivalence and Authority under a Tree Outside Delhi, May 1817. In J. Henry Louis Gates ed. "Race," *Writing, and Difference*. Chicago, University of Chicago Press.

Bogert, Carroll. 1995. "Midlife Crisis: The United Nations is Broke and Demoralized; But the World Still Needs It." *Newsweek*. October 30, 1995. Pp. 12-18.

Boggs, Carl. 1976. *Gramsci's Marxism*. London: Pluto Press.

Bradley, W. L. 1865. *Siam Then: The Foreign Colony in Bangkok before and after Anna*. Bangkok, Institute for Thai Studies, Thammasat University.

Bratton, Michael. 1994. "Civil Society and Political Transition in Africa." IDR Report, vol. 11, number 6. Institution for Development Research.

Chanet W. Khumthong. 2002 (2545). "The Politics and Socio-Economic Transformation of the Thai Health Care System" (in Thai). In Komatra and Chatichai, eds. *State of Knowledge in the History of Medicine and Public Health in Thailand*. Nonthaburi, Society and Health Insititute, Thailand. Pp. 106-174.

Chai-anan Samutwanich. 1976. *Sakdina and the development of Thai society* (in Thai). Bangkok: H.J.K. Nam Akson Printers.

Chaiwat Tiraphan. (2004) 2547. *The Future of Thai Politics and Global Democratic Governance* (in Thai). Nonthaburi: Society and Health Institute, Thailand.

Clark, J. 1991. *Democratising Development: The Role of Voluntary Organizations*. London: Earthscan.

Cohen, Jean, and Andrew Arato. 1992. *Civil Society and Political Theory*. Cambridge, MA: MIT Press,

Coleman, James S. 1988. "Social Capital in the Creation of Human Capital." *American Journal of Sociology,* 94 (supplement): 95-120.

Commission on Global Governance, The United Nations. 1995. "Our Global Neighborhood." Report of the Commission on Global Governance, reprinted in *The United Nations and Civil Society*. Boston: Boston Research Center for the 21st Century. Pp. 55-62.

Dodge, William R.1992. Strategic Intercommunity Governance Network. *National Civic Review* (Fall-Winter 1992): 403-417.

Falkenberg, Torkel and G. Tomson.2000 "The World Bank and Pharmaceuticals." *Health Policy and Planning* 15(1): 52-58.

Farrington, John, et al., eds.1993. *Non-Governmental Organizations and The State in Asia: Rethinking Roles in Sustainable Agricultural Development*. London and New York: Routledge.

Ferguson, J. 1994. *The Anti-Politics Machine: "Development," Depoliticization, and Bureaucratic Power in Lesotho*. Minneapolis, University of Minnesota Press.

Fernandes, Rubem Cesar. 1994a. "Threads of Planetary Citizenship." In *Citizens: Strengthening Global Civil Society*. M.D. de Oliveira and Rajesh Tandon, eds. Washington, DC: CIVICUS: World Alliance for Citizen Participation. Pp. 319-346.

1994b. "Private but Public: The Third Sector in Latin America." In M.D. de Oliveira and Rajesh Tandon, eds. *Citizens: Strengthening Global Civil Society*. Washington, DC: CIVICUS: World Alliance for Citizen Participation. Pp. 19-70.

Fraser, Nancy. 1992. "Rethinking the Public Sphere: A Contribution to the Critique of Actually Existing Democracy." In C.J. Calhoun, ed. *Habermas and the Public Sphere*. Cambridge, MA: MIT Press.

Garthy, Vera, ed. 1989. *State and Civil Society: Relationships in Flux*. Budapest.

Gramsci, Antonio. 1971. *Selections from the Prison Notebooks*. Quintin Hoare and Geoffrey Nowell Smith, eds and transl. New York: International Publishers.

Habermas, Jurgen. 1989. The *Transformation of Public Sphere: An Inquiry into a Category of Bourgeois Society*. Thomas Burger, transl. Cambridge, MA: MIT Press.

Hann, Chris and Elizabeth Dunn, eds. 1996. *Civil Society: Challenging western models*. London and New York: Routledge.

Health Systems Reform Office (HSRO). 2003 (2546). *Peaceful Death and Dying with Dignity* (in Thai). Nonthaburi: Health Systems Reform Office, Thailand.

Hobsbawm, Eric. 1994. *The Age of Extreme: The Short Twentieth Century*. Oxford: Oxford University Press.

Hoffman, Beatrix. 2003. "Health Care Reform and Social Movements in the United States." *American Journal of Public Health*. 93 (1): 75-85

Ingram, J. C. 1971. *Economic Change in Thailand,* 1850-1970. Stanford, Stanford University Press.

Jareg, Pal, and Dan Kaseje. 1998. "Growth of civil society in developing countries: implications for health." *Lancet* 351: 819-822.

Jennings, B. and M. J. Hanson. 1995. "Commodity or Public Works? Two Perspectives on Health Care." *Bioethics Forum,* (Fall 1995): 3-11.

Kari, N., H. C. Boyte, & B. Jennings et al. 1994. "Health as a Civic Question." Prepared for American Civic Forum. November 28, 1994. Available online at http://www.cpn.org/topics/health/healthquestion.html.

Keane, John. 1988a. "Despotism & Democracy: The Origin and Development of the Distinction Between Civil Society and the State." In J. Keane, ed. *Civil Society and the State: New European Perspective*. London: Verso.

1988b. Democracy and Civil Society. London: Verso.

Keating, Michael. 1994. "North America's Independent Sector." In Oliveira, Miguel D. de, and Rajesh Tandon, eds. *Citizens: Strengthening Global Civil Society*. Washington, DC: CIVICUS; World Alliance for Citizen Participation. Pp. 71-105.

Keyes, C. 1987. *Thailand: Buddhist Kingdom as Modern Nation-State*. Boulder & London, Westview Press.

Kim, Jim Yong, et al., eds. 2000. *Dying for Growth: Global Inequality and the Health of the Poor*. Monroe, Maine: Common Courage Press.

Komatra Chuengsatiansup & Chatichai Mooksong, eds. 2002 (2545). *State of Knowledge on the History of Medicine and Public Health in Thailand* (in Thai). Health Systems Research Institute, Nonthaburi, Thailand.

Komatra Chuengsatiansup, Nonglak Trongsilsat & Pot Kritkraiwan, eds. 2002 (2545). *Dimensions of Health: Towards a New Paradigm for Social Health* (in Thai). Nonthaburi: Health Systems Research Institute. Thailand.

Komatra Chuengsatiansup & Sumaporn Sae-Lim, Eds. 2002 (2545). *Critical Issues in National Health Development during the Ninth National Health Plan* (in Thai). Nonthaburi: Bureau of Health Policy and Planning, Ministry of Public Health. Thailand.

Komatra Chuengsatiansup, et al. 2004 (2547). *Ethnicity and Medicine* (in Thai). Bangkok, Sirindhorn Anthropological Center.

Kongsakol Kawinraweekul. 2002 (2545). "The Construction of Citizen's Body during the Phibun Regime (2481-2487 B.E.)" (in Thai). Master Thesis. Department of Sociology and Anthropology. Bangkok, Thammasat University.

Korten, David. 1995. When Corporations Rule the World. Kumarian Press and Berrett-Koehler Publishers.

2000. "The Civil Society: An Unfolding Cultural Struggle." available online at http://cyberjournal.org/cj/authors korten/CivilizingSociety. shtml.

Lyttleton, C. 2000. *Endangered Relations: Negotiating Sex and AIDS in Thailand*. Bangkok: White Lotus.

Martinez Valle, Adolfo. 2000. "Politics and inequality in Mexico's health care reform." Paper presented at the 128th Annual Meeting of APHA.

Mcfarland, G. B. 1928. *Historical Sketch of Protestant Mission in Siam*, 1828-1928. Bangkok: Chulalongkorn University.

Mills, C. Wright. 1959 The Sociological Imagination. New York: Oxford University Press.

Ministry of Public Health. 2001. The Ninth National Health Development Plan (2002-2006) (in Thai). Nonthaburi: Bureau of Health Policy and Planning, Ministry of Public Health.

2002. Thailand Health Profile. Nonthaburi: Bureau of Health Policy and Planning, Ministry of Public Health.

Mogedal, Sigrun. 1998. "Supportive Functions of International Health Organizations." Paper for Meeting on World Health, Mexico City, 29 March 1998 - 1 April 1998.

Morgan, L. 1993. *Community participation in health, The politics of primary care in Costa Rica*. Cambridge, UK, Cambridge University Press.

Nagengast, Carole. 1991. *Reluctant Socialists, Rural Entrepreneurs: Class, Culture, and the Polish State*. Boulder, San Francisco and Oxford: Westview Press.

Oliveira, Miguel D. de, and Rajesh Tandon, eds. 1994. *Citizens: Strengthening Global Civil Society*. Washington, DC: CIVICUS.

Osborne, David, and Ted Gaebler. 1992. *Reinventing Government: How the Entrepreneurial Spirit is Transforming the Public Sector*. Reading, MA: Addison-Wesley.

Pasuk Phongpaichit and Chris Baker. 1998. *Thailand's Boom and Bust*. Bangkok: Silkworm.

Pensri, Kaweewongprasert. 1985 (2528). "The Roles of Thai State on People's Health Problems (2325 B.E. to after the change of political regime in 2475 B.E.)" (in Thai). Master Degree Thesis, Department of Social Sciences and Humanities. Nakhonpathom, Mahidol University.

Putnam, Robert. 1993a. *Making Democracy Work: Civic Traditions in Modern Italy*. Princeton: Princeton University Press

2000. *Bowling Alone, The Collapse and Revival of American Community*. New York: Simon & Schuster.

Riggs, F. W. 1966. *Thailand: The Modernization of a Bureaucratic Polity*. Honolulu, East-West Center Press.

Rong Sayamanont. 1977 (2520). *History of Thai under the Constitutional Regime* (in Thai). Bangkok: Thai Wattana Panich.

Salamon, Lester M. et al. 1999. *Global Civil Society: Dimensions of the Nonprofit Sector*. Baltimore, MD.: The Johns Hopkins Center for Civil Society Studies.

Saligman, Adam. 1992. *The Idea of Civil Society*. New York: The Free Press.

Sanguan Nitayarumphong & Anne Mills. Eds. 1998. *Achieving Universal Coverage of Health Care: Experiences from Middle and Upper Income Countries*. Nonthaburi: Office of Health Care Reform, Ministry of Public Health. Thailand.

Siffin, W. J. 1966. The *Thai Bureaucracy: Institutional Change and Development*. Honolulu, East-West Center Press.

Skocpol, Theda. 1995. "The Rise and Resounding Demise of the Clinton Plan." *Health Affair*, 14 (spring): 66-85.

Soccorso, Andrea. 1994. "The Role of Development NGOs in Strengthening Civil Society." Master thesis, Kennady School of Government, Harvard University.

Starr, Paul. 1994. "The Disengaged." The American Prospect (Fall 1994): 7-8.

1995. "What Happened to Health Care Reform?" The American Prospect 6 (20), December 1, 1995 .

Stocking, G. W. J. 1987. *Victorian Anthropology*. New York, Free Press.

Stowe, J. A. 1991. *Siam Became Thailand: A Story of Intrigue*. London, Hurst & Company.

Suwit Wibulpolprasert, ed. 1997 (2540). *Civil Society and Health Development: An Analytical Review* (in Thai). Nonthaburi: Health Systems Research Institute, Thailand.

Suwit Wibulpolprasert, ed. 2003 (2546). 25 *Years of Rural Doctor Movement in Thailand* (in Thai). Bangkok: Rural Doctor Foundation.

Suwit Wibulpolprasert & Komatra Chuengsatiansup, eds. 1987 (2530). *Thai Traditional Medicine: Local Wisdom for Self-Reliance* (in Thai). Bangkok: Folk Doctor Press.

Tan, Gerald. 1993. The Next NICs of Asia. *Third World Quarterly*, 14 (1): 57-73.

Tej Bunnag. 1976. *The Provincial Administration of Siam*, 1892-1915. London, Oxford University Press.

The World Bank. 1984. "Thailand: Managing Public Structural Adjustment." A World Bank Country Study. Washington, DC: World Bank.

Thavitong Hongvivatana, et al. 1988. *Alternatives to Primary Health Care Volunteers in Thailand*. Nakornpathom, Thailand: Center for Health Policy Studies, Mahidol University

Thaweesak Pueksom. 2000 (2543). "Western Medicine Discourse and the Rule of Thai State: An Initial Reflection" (in Thai). *Journal of Thammasat University* 26 (2): 73-93.

2002 (2545). "Modern Medicine in Thai Society" (in Thai). A research report summitted to The Thailand Research Fund.

Therayut Boonmee. 1993. (2536) *Strong Society* (in Thai). Bangkok: Ming Mitr.

Tocqueville, Alexis de. 1947. *Democracy in America*. Volume II. New York: Alfred A. Knopf.

Turton, A. 1980. "Thai Institutions of Slavery." In J. L. Watson ed. *Asian and African Systems of Slavery*. Oxford, Basil Blackwell: 251-292.

Vichai Chokwiwat. 2002a (2545). "Important Reforms of Health Care System in Thai Society between 2431-2543 BE" (in Thai). In Komatra Chuengsatiansup & Chatichai Mooksong, eds. *State of Knowledge on the History of Medicine and Public Health in Thailand*. Nonthaburi, Thailand: Health Systems Research Institute.

2002b (2545). "Diseases Prevention and Control: A New Challenge (in Thai)." In Komatra Chuengsatiansup & Sumaporn Sae-Lim, Eds. *Critical Issues in National Health Development during the Ninth National Health Plan*. Nonthaburi, Thailand: Bureau of Health Policy and Planning, Ministry of Public Health.

Walt, Gill. 1996. "Enhancing Performance of International Health Institution: Pocanito Retreat," reprinted in "Rx for Global Health Cooperation Beyond 2000," a report from the Conference on World Health Cooperation Beyond 2000. Chulalongkorn University School of Public Health, London School of Hygiene and Tropical Medicine, Mexican Health Foundation, and Overseas Development Council.

1998. "Crisis of Identity: Health cooperation in a global network." Paper from the Meeting on World Health, Mexico City, 1998.

Walzer, Michael. 1992. "The Civil Society Argument." In C. Mouffe, ed. *Dimensions of Radical Democracy: Pluralism, Citizenship, Community*. London: Verso. Pp. 89-107.

Wapner, Paul. 1995. "Politics beyond the State: Environmental Activism and World Civic Politics." *World Politics* 47 (April 1995): 311-340.

Wariya Siwasariyanon. 1984. "The Transfer of Medical Technology from the First World to the Third World: A Case Study of the Rockefeller Foundation's Role in a Thai Medical School (1932-1935)." Ph.D. dissertation, Universtiy of Hawaii.

Weir, Margaret. 1995. "Institutional and Political Obstacles to Reform." *Health Affair,* 14 (Spring): 102-104.

Weisbrod, Burton A.1988. *The Nonprofit Economy*. Cambridge, MA: Harvard University Press.

Williams, A. 1990. "A growing role for NGOs in development." *Finance and Development*. December 31: 3.

World Health Organization. 1981. *Global Strategy for Health for All by the Year 2000*. Geneva: World Health Organization.

Wyatt, D. K. 1969. *The Politics of Reform in Thailand: Education in the Reign of King Chulalongkorn*. New Haven, Yale University Press.

Yankelovich, Daniel. 1995. "The Debate That Wasn't: The Public and the Clinton Plan." *Health Affair,* 14 (Spring): 8-23.

Yongyuth Kachondham & Somsak Chunharas. 1993. "At the Crossroads: Challenges for Thailand's Health Development." *Health Policy and Planning,* 8 (3): 208-216.

Yuthana Warunpitikul & Sunita Rerngjit, eds. 2000 (2543). *Citizen Consciousness* (in Thai). Bangkok: Foundation for Civic Education and Civil Society Development.

The most important aspect of mobilizing civil society in health systems reform was the creation of the civic deliberation process... Health, as it was percieved and deliberated in civic forums, was not so much an individualized, depoliticized state of being achievable solely by individuals adopting a personal healthy lifestyle and passively following official authority or bureaucratic policy. Rather, health was viewed as socially determined, and public policies that often greatly affect health were deemed too important to be left to bureaucrats, politicians, and experts. It was this shift in the view of health, and of health policies and politics away from the conventional model to one that embraced the active roles of citizens that can be said to be the true object of reform.

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